mental health digest

National Clearinghouse for Mental Health Information, Vol. 1, No. 8, August 1969

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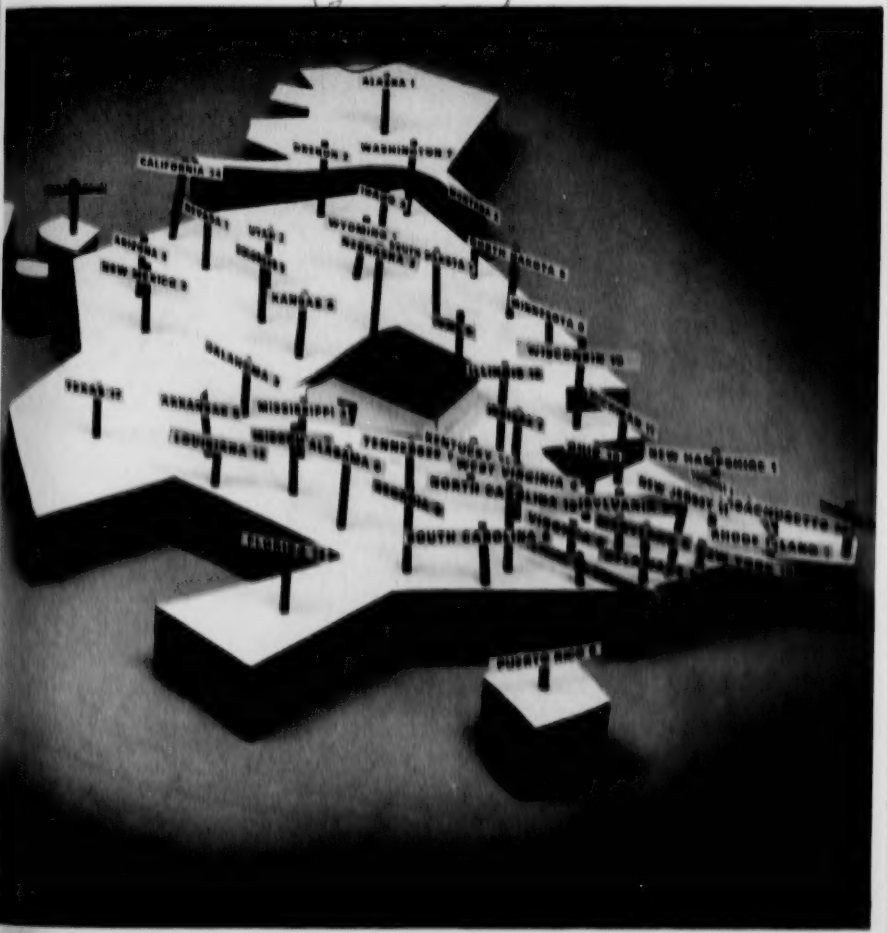

cover story

This stylized map of the United States shows the distribution of community mental health centers around the country. There is now at least one center in each of the 50 States, as well as in Puerto Rico and the District of Columbia. More than 200 centers are actually in operation. See story, page 40.

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The *Mental Health Digest* is a monthly publication of the National Institute of Mental Health. Designed to reflect the whole spectrum of mental health and to present a broad sampling of scientific subject matter and professional points of view, the *Digest* contains condensations of selected current journal articles, reviews, Federal and State program documents, and other pertinent material.

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Use of funds for printing this publication approved by the Director of the Bureau of the Budget, May 20, 1968.

Evaluation of Alcoholism Treatment: A Comparison of Three Facilities

E. Mansell Pattison, Ronald Coe, and Robert J. Rhodes

Alcoholism treatment programs have been based on a simple model of treatment that assumed that there is one population of alcoholics, to be treated by one best method, which would produce one therapeutic result —abstinence. Research has suggested that these dimensions consist of several subsets of variables.

The development of a rational approach to treatment must take into account the observed variabilities within the patient population, treatment method and facility, and treatment outcome. The simple unilinear model assumes that each of the three dimensions is homogeneous. If we consider that each dimension may be heterogeneous, several models for relationships between these dimensions can be logically suggested. The model that represents our view suggests that outcome variability is due to both a variable patient population and variables in treatment facilities.

This study compared the population characteristics of alcoholics treated at three alcoholism treatment facilities, both at the time of intake at the facility and subsequent to treatment.

Facility 1 is a private medical hospital specializing in the treatment of alcoholics. The major treatment modality is aversion-conditioning. Various psychotropic drugs are used, patients are maintained in a positive supportive milieu, and most patients have psychiatric interviews under thiopental. Emphasis is on a biochemical etiology of alcoholism; the goal is abstinence. Treatment is conducted over ten days to two weeks, with followup visits. Treatment may cost several thousand dollars.

Facility 2 is a mental health outpatient clinic for alcoholics. It offers psychiatric and social work counseling on an individual and group basis. Psychotropic drugs and disulfiram are occasionally used. Although abstinence is a goal, it is not a requisite for continuing, nor is failure to achieve abstinence defined as a treatment failure. The focus is on causes and consequences of drinking. Emphasis is placed on changes in psychological and social functioning. Fees are on sliding scale.

Facility 3 is a halfway house for male alcoholics which offers residence to maintain sobriety and reestablish vocational stability. Abstinence is required. An active program of self-government is maintained. Some nonprofessional counseling is afforded families of residents, some vocational counseling is available, and attendance is required at Alcoholics Anonymous meetings. Charges, at cost, are made for living in the house.

At the conditioning hospital, patients whom the administration considered successfully treated, i.e., were abstinent at that time, were drawn from the files. It is not surprising that in this outcome population we found no limited drinkers and only one unsuccessful drinker. The unsuccessful drinker was discarded from our analysis.

At the outpatient clinic, we initially selected a random population, which

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turned out on interview to contain ten abstinent, two limited drinkers, and five unsuccessful drinkers, according to our criteria. All these patients had been discharged as improved. We discarded only the unsuccessful drinkers.

At the halfway house, the sample consisted of patients who were linked to the facility through an alumni club, one of the criteria of success by the facility. We found 17 abstinent, two limited drinkers, and one unsuccessful drinker. The unsuccessful drinker was discarded from our analysis.

What were the patterns of interaction that occur between population, facility, and outcome?

The outcome of treatment is not unidimensional. The changes in drinking scores and the changes in other scale scores on other health dimensions do not change together. This is not to say that improvement in drinking is not related to improvement in other areas of life function, but that the relationship is not a directly linear one. Indeed, the abstinent patients tend to show improvement in all areas of life functioning. But the abstinent patients from each facility show different patterns of improvement in each of the other areas of life functioning.

We also looked at the data on those who were the unsuccessful drinkers (and discarded from the prior analysis). Even though they had not improved in their drinking behavior, their treatment was not totally unsuccessful in terms of the other scales of life health. There was marked improvement in the area of interpersonal relationships, almost the same amount of improvement as the successful abstinent patients at the conditioning hospital. Nor is the improvement in interpersonal relationships unexpected, since this is a major therapeutic goal of the outpatient clinic where they were treated.

Another subgroup were the "successful" treatment cases, who were found to be drinking to a limited degree. These persons' improvement in other areas of life health was intermediate between the abstinent and the unsuccessful drinkers. The limited drinkers still had an alcoholism problem. They continued to have difficulties in other areas of life function, with minimal improvement if at all in those areas. These limited drinkers were considered successful treatment cases even though they did not achieve the ideal criterion of success set by the facility.

What were the differences between populations presenting themselves to each facility, the treatment and goals of each facility, and how did these variables relate to the observable outcomes?

The patients at the conditioning hospital at the time of intake were relatively "less sick." Thus there would be "less room for improvement." This represents the so-called "ceiling effect" noted in research work on the outcome of psychotherapy. The patients at the conditioning hospital were upper class, relatively wealthy persons, whose alcoholism had not totally disrupted their social and vocational life. They maintained excellent jobs, there was more observable family integrity, and minimal isolation from meaningful relations with others. These persons have been described as "high bottom" alcoholics. They may seek treatment earlier, and more social and vocational pressures may push

them into treatment than the populations at the other facilities.

This facility seems to reflect the needs and perceptions of the population it serves. The population is "high class" and the treatment is "high priced." The population uses medical explanations for alcoholism as a defense against viewing alcoholism as a personal problem. In contrast to the halfway house, with its attendant AA philosophy or the outpatient clinic with its stress on self-evaluation, the conditioning hospital presents a method of treatment which allows its patients to maintain their image of adequate, successful individuals who are afflicted with a disease that requires medical treatment. One can observe these relationships in the treatment outcome: drinking is much improved, there is minimal change in social or vocational functioning, and there is relatively low perception of emotional problems or observed changes in psychological functioning.

The patients at the halfway house show a different pattern. The situation is just the reverse of the conditioning hospital. These people were "low bottom" alcoholics. This population could be considered "more sick," hence having "more room for improvement." This population was made up of people who, if not on skid row, were close to it. The majority were unemployed, their marriages and families broken up, and friendships were only casual contacts with "drinking buddies."

The facility was well geared to meet the needs of its population. The halfway house provided for the gratification of daily needs and desires, as well as providing rigorous limit-setting and behavior-defining boundaries necessary for persons who had limited ego strengths at the time of admission. The AA philosophy emphasized the need to change one's whole orientation toward life and toward oneself, and this matched the fact that alcoholism had destroyed these persons' lives and that a reconstruction of their pattern of living was needed.

The population at the outpatient clinic presents a third pattern. They are middle-class persons in whom alcohol is causing demonstrable disruptions in social and vocational function, with some physical concomitants. They have perhaps less need to maintain status by using the medical rationalizations employed by the conditioning hospital patients, and the alcoholism affects more areas of their life, hence undercutting the possibility of denial. On the other hand, they do maintain a degree of effective functioning. Thus they represent a population for whom the concept of emotional illness is a feasible way of defining alcoholism, and they can sustain themselves while engaged in psychotherapy.

This study suggests that more attention be given to characteristics of the population of a facility, and that explicit attempts should be made to develop treatment methods geared to the needs of that population.

It also suggests that no one facility can provide a "comprehensive" treatment program for all types of alcoholic populations. Or if a comprehensive facility were to be established, it would require careful development of parallel-type programs.

The Negro Psyche: Fact, Fiction and Fantasy

ALYCE C. GULLATTEE

Over the past decade, every facet of Negro life has suddenly loomed important to all, black and white alike. The aspect which arouses most concern and speculation is his black behavior.

What has this ethnic analysis produced? Upon what premises has it been made? What is the validity of the findings? One suspects that many generalizations propounded by the "student voyeurs" of Negro behavior may reflect beliefs of the investigator which have become part of his fantasy life and ethnic mythical reservoir. Yet apart from the possibility of specious theorizing about the Negro, which in itself would justify taking another critical look at the literature, there is always the need for science to reexamine the premises upon which it hypothesizes.

Because "experts" on the Negro are almost exclusively non-Negro, the Negro most often learns who he is through an outside source whose perceptions may be distorted and/or naive. The samplings are usually small; the population may represent an abnormal group from which are extrapolated "facts" that are then applied to the normal group. Comparative reference groups are socioeconomically unequal, e.g., lower-class Negroes are compared with middle-class whites where obvious discrepancies will occur.

Such studies reflect the preconceived ideas of the investigator, e.g., low incidence of suicide in Negroes of the South reflects their inability to become depressed to the point of hopelessness and self-annihilation. The superintendent of a large Negro mental compound in the South expressed the idea that if suicide occurs in the Negro, it is *prima facie* evidence that there is white blood present. The Negro is over-diagnosed in some categories, under-diagnosed in others, given selective treatment and perhaps none at all if a presenting symptom is believed to be a "cultural characteristic."

The Negro is variously described as a product of a matriarchal family that serves as a poor interpreter of social expectations and as a source of ego strength. Although part of the fault rests with the white culture in not allowing the Negro to participate in its social institutions, it is implied that inherent cultural characteristics of the Negro predispose him to a low level of aspiration, a fragile character structure, and a family identity. To compensate for his own sense of low esteem, he identifies with the aggressor by acquiring prejudicial attitudes toward other minorities, by releasing anger onto himself, and by denying complicity in his own negligent and deficient behavior.

It is said that as a child and as a youth the Negro demonstrates hate for his color and an inability to discuss his feelings about whites; he uses his inferior position as an excuse to rationalize his poor performance; and as an adult the Negro demonstrates his inability to adjust adequately to his marginal status without contingent anxiety.

Interestingly enough there is a paucity of research to refute these asser-

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tions, and that which is available has been written, with few exceptions, by Negro investigators. There is no comparative literature about whites in similar ethnocentric circumstances in America and little or no literature about the "normal Negro." On the contrary, normal standards for the black American would seem to be derived from the studies of the abnormal. Or it may be that the opprobrium of color in America is synonymous with abnormality.

The concept of ego strength, balance of adaptation to internal and external environmental stress or body image are part of the psyche of the individual. Self-conceptualization and identity formation occur simultaneously and continuously. During normal maturative development the individual child, adolescent, and adult will undergo a process of assimilation with what has been his self-concept to form his identity. The self-concept would answer the question of "What am I?" and identity the question "Who am I?"

The ego has basically five integrative divisions: ego functions that express the aims of the drives for pleasure, object attachment, and assertive mastery; defense mechanisms and associated emergency emotions, i.e., anger, pain; the ego ideal created by parental identifications and the incorporation of social imperatives; the super ego, working through "conscience" and the affect of guilt; and the self, a substructure of the ego which includes self representations and the narcissistic standard of personal omnipotence by which each person ultimately judges his own performance.

One can see that the Negro experiences crippling traumata to almost every part of his ego development.

Unfortunately for the black child he is the victim of a vicious cycle inasmuch as his experience is largely a reflection of societal attitudes about black people. Not only are whites convinced of the validity of that which they hear and see about blacks; some Negroes too are brainwashed into believing the same.

It becomes difficult for the unsophisticated mechanisms of the child and the childlike adult to comprehend a description of the Negro that defines him as a potential schizophrenic whose only definitive role is as a good provider to his family (conjugal or not), one who is permitted to act out his anger and hostility through sexual roles and repress his true emotions over his despicable state of servitude. If he releases energy by having positive feelings about himself and evaluates environmental stimuli correctly, he is labeled as hostile and aggressive. If he is prejudiced, he is categorized as having a particular type of personality, the authoritarian. This type bears the mark of an unresolved conflict about his own identity to an extraordinary extent. Any identity that is positive and proud is heralded as new and has come only with integration, upward mobility, and the emergence of African nations. Whites have for some reason failed to accept the fact that Negroes can see themselves in a positive light.

The one aspect of behavior that has gained prominence and generated concern in recent months is the super-ego function of the Negro and his revolutionary activity. The literature suggests that certain aspects of the Negro behavior can be attributed to identification with the aggressor but no clarification is offered.

Classically, identification may be: with the dreaded external object;

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with what the individual imagines the object is like, e.g., the Negro's attempt to look like the white cultural norm of beauty; identity not with the person of the aggressor but with his aggression; identification with the masculinity or femininity of the aggressor; and transformation of energy onto an anticipated act of aggression in the future. When one acts out the aggression with which he has identified, it is against the world at large; however, when the aggression is turned against the source of anticipated aggression and not a substitute, the role of attacker and attacked is carried to its logical conclusion.

An ego which develops along the lines utilizing projection introjects the authorities to whose criticism it is exposed and incorporates them in the super ego. It is then able to project its inhibited impulses outward. It may be intolerant to other people prior to self-criticism. It learns what is blameworthy, but protects itself from self-criticism. This stage is a kind of preliminary phase of morality in the development of the super ego. Maturity is present when the internalized criticism coincides with the ego's perception of its own fault. It is possible that a number of people remain arrested at the intermediate stage in the development of the super ego and although perceiving their own guilt, they continue to be peculiarly aggressive in their attitude toward other people. Therein lies the concept of white racism.

Identification with the aggressor is normal only when used by the ego to resolve conflict with authority in an effort to deal with anxiety. The Negro's identification is thus not of pathological significance. The action of militants reflects identification by blacks with real aggression from the dominant white society and thus the action against society at large. Even the concept of identification with the aggressor is a hazy, although frequently used, phrase in the writings of the experts on the Negro.

There can be no doubt that the Negro is a precious commodity as attested to by the governmental agencies' willingness to underwrite studies on him. And perhaps the misinformation which issues from these may be connected with the current events of the day and the perpetuation of the fiction and the fantasy that surround the black man.

The Pollyanna Hypothesis

JERRY BOUCHER AND CHARLES E. OSGOOD

In this paper we present evidence for what we call "the Pollyanna Hypothesis," a universal human tendency to use evaluatively positive (E+) words more frequently, diversely, and facilely than evaluatively negative (E−) words. Put more simply, humans tend to "look on (and talk about) the bright side of life." This hypothesis generates a number of specific and testable hypotheses, e.g., lexicons will include more E+ than E− terms; for words matched on other grounds, E+ items will be used more frequently than E− items; E+ words will appear earlier in the vocabularies of children than matched E− words; other things equal, E+ words will be easier to learn and recall than E− words; other things equal, again, E+ words will have lower recognition thresholds than E− words; and so on.

Frequency and Diversity of E+ and E− Across Languages

Pollyannaism is hypothesized to be a human universal. All human languages have means of qualifying (adjectives) substantives (nouns), and all languages of which we are aware utilize the principle of opposition in structuring their modes of qualifying. The Pollyanna Hypothesis leads to the prediction that E+ qualifiers will be used more frequently than E−; it also predicts that E+ qualifiers will display greater diversities of usage.

A set of 100 culture-common substantives (e.g., hand, sky, sympathy, defeat, mother, etc.) was translated into each of the languages under study. These were presented to 100 high-school boys as stimuli in a restricted word-association task, the subjects being instructed to give the first qualifier that occurred to them for each substantive, e.g., *tree*-green, *house*-big, *girl*-pretty in English. The sample of 10,000 qualifier-tokens from each community was analyzed with computer programs designed to determine for each qualifier-type, its frequency of usage over all nouns, its diversity of usage across the 100 nouns, and its independence of usage across the 100 nouns when correlated with other qualifier-types. The first two measures can be combined in the single H-index of information theory statistics.

The Pollyanna Hypothesis is clearly supported. With a single exception (Finnish on diversity), in every language E+ words display higher average H-ranks, frequencies, and diversities than E− words. For seven languages (French, Italian, Dutch, Mexican, Spanish, Afghan Farsi, Cantonese, and Turkish) the differences are highly significant. The Pollyanna effect is weakest for American English, Finnish, and Yugoslav Serbo-Croatian. The effect is consistent across the three measures—the more diversely used E− words also tend to be the more frequently used.

Applying Negative Affixes Cross-Linguistically

Negative affixes are applied to an already existing form in a language to reverse its meaning. In English, such negations usually appear as prefixes—*in*decent, *im*moral, *dis*honest, *un*happy, *non*sense, etc. In other lan-

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guages negations may appear as suffixes, as well as prefixes, so we use the term *affix*. Negative affixes can be used in either of two ways: added to a positively evaluated word to form a negatively evaluated opposite (e.g., happy–unhappy, moral–immoral); added to a negatively evaluated word to form a positively evaluated opposite (e.g., broken–unbroken, violent–nonviolent).

That the latter are relatively rare in English can be demonstrated by the reader himself, by trying to think of other instances. The Pollyanna Hypothesis leads to the prediction that, for human languages generally, negative affixes will be applied to E+ words more frequently than to E− words. This is because the hypothesis assumes priority of E+ words in appearance in a language historically as well as in the development of language in individuals and negative affixes must be applied to already existent meaningful forms.

The same qualifier data from the cross-cultural project on generality of semantic systems were used. Identification of negative affixes was obtained from native speakers. The 50 final pairs of qualifier-opposites in each language, defining its semantic differential scales, constituted the sample. Cantonese Chinese and Finnish had to be excluded, the former qualifier data yielding no negative affixing and the latter only one instance.

In every one of the 11 languages, negative affixing is applied to the E+ member more often than to the E− member. For six languages (Belgian Flemish, French, Italian, Iranian Farsi, Netherlands Dutch, and Yugoslav Serbo-Croatian), the differences are significant. The Pollyanna Hypothesis is clearly supported.

The hypothesis leads to a correlated prediction: where the negative affix is applied to the E− word, its H-rank should be higher than the E+ word, contrary to the general rule. The derivation of "nonviolent" from "violent" may be a case in point. Checking this prediction against the data, we find that in every case where the negative affix is applied to the E− member, this member has the higher H-rank; where the negative affix is applied to the E+ member, this member usually, but not always, has the higher H-rank.

Development of E+ and E− Evaluation

Here we shift from comparisons across languages and cultures to comparisons across age levels within the American English community. The Pollyanna Hypothesis leads to the following expectations: the E+ members of pairs should appear earlier in the language of children than their E− opposites. This could be due to the direct operation of Pollyannaism in humans, but it could also be due to the greater availability of E+ qualifiers in adult language. Frequency and diversity of usage of E+ members of pairs should be higher than their E− opposites for all age levels, but the difference should decrease with age. The decreasing E+/E− ratio would be due to the relative increase in negative evaluation with age. Use of negative prefixes should be a late-occurring phenomenon, and nearly all such affixing should be onto the E+ member to make the E− opposite. The prediction of late occurrence is consistent with the delayed use of affixes generally in language development.

In every case where one member has an H-rank and the other does

not, it is the E+ member that is ranked. This supports the first prediction. In every case where both members are ranked, the E+ member has the higher rank—supporting the second prediction.

The final step was to check the prediction relating to use of negative affixes. Inspection of the top 100 H-ranked qualifiers at all age levels revealed only two instances of negative affixing, both applied to E+ forms; such sparse usage precludes quantitative analysis, but it is testimony to the late appearance of negative affixing.

Inspecting the raw data for different age levels, and noting those negatively prefixed qualifiers given more than once to a noun in at least one age group, we find only 10 types (different words) comprising only 64 tokens (occurrences), and this by age 11. This is a very small proportion. With the "idiosyncratic" responses—qualifiers given only once to a given noun in a given age group—we find that there are only four tokens of four types at age 7 and only 114 tokens divided among 80 types at age 11. However, the rate of increase in negative affixing types is much more rapid between ages 9 and 11 than for total types, suggesting that during this period of development the use of negative affixes has been established and is generalizing.

These results are again consistent with the cross-cultural data on the Pollyanna Hypothesis.

We are left with the question of why E+ words are used more frequently by humans than E— words. Why do most people most of the time in most places around the world talk about the good things in life? Why do they tend to see and report the good qualities of things? The answer surely goes beyond psycholinguistics per se and into the nature of human social structures and the conditions under which these structures can be maintained. It is hard to imagine human groups whose members persistently look for and talk about the ugly things in life and in their neighbors long remaining together. We leave further elaboration to social philosophers.

Sex Ratios of Newborns: Associated with Prepartum and Postpartum Schizophrenia

M. A. Taylor

Charts of female patients at Manhattan State Hospital were reviewed, and all documented pregnancies associated with sudden onset of psychotic symptoms but without maternal neurological or medical illness were selected. The first appearance of psychotic symptoms was used as the criterion for onset of illness. Diagnosis of schizophrenia was required.

Fifty-four pregnancies met the criteria. All conceptions had occurred out of hospital, and three-quarters had occurred before the mother became mentally ill. Twenty conceptions had occurred during or shortly after treatment with a neuroleptic drug. There were 49 full-term births, 20 males and 29 females.

Of 13 women who became psychotic within one month of conception, two were receiving neuroleptic drugs throughout gestation; all their offspring were female. Of 13 women who became psychotic within two months after parturition, 2 delivered females and 11 delivered males.

There were five spontaneous abortions at the onset of the mother's schizophrenia, two within the first month, one during the first trimester, and two during the second trimester. Sex of the aborted fetuses was not recorded.

Among the defective offspring, there were four stillbirths, all male. Two newborns who died within four days after birth were males. Of six offspring with birth defects, five were male. Absence of male live births when conception and psychotic onset coincide and the predominance of birth defects in males suggest that when the mother becomes psychotic within one month of conception the male embryo is destroyed. When the mother becomes psychotic during the second or third month of pregnancy, the male fetus develops abnormally or dies.

I also studied 26 pregnancies where the mother became psychotic during the first month after delivery. Twenty-two were associated with delivery of a male and four with delivery of a female. These data suggest a causal relation between the birth of a male child and a postpartum schizophrenia. I believe postpartum schizophrenia to be a release phenomenon, secondary to birth of the male fetus and to the withdrawal from the mother of the male hormonal influence. Treatment of postpartum psychoses with progestins and androgens indicates that this influence may involve progesterone and testosterone.

My data may indicate that the onset of schizophrenia in the mother is an initiating event. If the mother is acutely schizophrenic during the first month of her pregnancy, the male fetus succumbs, whereas if the onset of schizophrenia occurs later in the pregnancy, the fetus may physiologically "defend" itself by the production of functionally high hormone levels which suppress the disease in the mother, perhaps by preventing the production, or enhancing the breakdown of a toxic blood factor in the schizophrenic mother. Delivery of a male fetus unmasks the mother's schizophrenia, with an effect similar to that of abrupt withdrawal of a neuroleptic drug.

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Children of Schizophrenic Parents

I. V. Kraule

We studied 54 children of schizophrenic parents. Age of the children (34 girls, 20 boys) ranged from 1-1/2 to 15 years (19 under 7 years old, the others of school age).

Children of Schizophrenic Mothers

We observed 37 children from 28 mothers. The children were divided into four subgroups. In the first subgroup were four children who suffered from slow progressing schizophrenia, gradually increasing reticence, hostility toward relatives, fear, unmotivated laughter, and some displasticity in habitus. They were inert, passive, and inclined to dream. Delusional mood was observed in three children of school age. Three mothers were schizophrenic during pregnancy, but they were not treated with psychotropic drugs. One mother, suffering from periodic schizophrenia, became ill after the birth of her child. However, extensive heredity in this family was established in four generations. Anamnesis of the children included additional unfavorable factors such as asphyxia during birth and grave intercurrent disorders during the first year of life.

The second subgroup comprised 18 children in whom neurotic disorders were leading. They were physically weak, asthenic, and pale. Disorders of sleep and appetite were observed from the first years of their life. The parents complained about their children being nervous, restless, touchy, and whining. Periods of depression were observed in three children. Thirteen were sociable, five enjoyed being in seclusion, three were rude and quick-tempered, two suffered from nocturnal enuresis, one stuttered. Intellect was adequately developed in all these children. During pregnancy the mothers were in a satisfactory condition; five of them received aminazine, three became schizophrenic after childbirth. Complications during childbirth were observed in four cases. Two children were born prematurely. However, these complications had no deep damaging effect on the brain; psychomotor development of the children progressed normally. The genealogical analysis of five families on the mother's side established schizophrenia; psychopathy and chronic alcoholism were observed in five families.

The third subgroup comprised five children in whom symptoms of organic damage of the central nervous system with delayed mental development were observed. Symptoms of damage of craniocerebral nerves were observed: convergent stabismus, asymmetry of face, deflection of tongue, muscular dystonia, and tremor. Psychomotor development was delayed. There were also neurotic disorders, such as disorder of the rhythm of sleep and motor unrest. Anamnestic data indicated additional injurious factors, which affected embryonic development and childbirth. In two women traumas were observed during pregnancy; in three, birth complications. Schizophrenia was not aggravated during pregnancy. Only one woman was treated with psychotropic drugs; there was no schizophrenia in

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Condensed from the *Zhurnal Nevropatologii i Psikhiatrii imeni S. S. Korsakova*; 89(2):238–241; 1989.

relatives, but there were instances of psychopathy, chronic alcoholism, and endocrinopathy.

The fourth subgroup comprised 10 children whom we consider normal; however, in three children some characterological manifestations appeared: they were ambitious, sthenic, and they want to be first in everything. Mothers of these children became schizophrenic only after the birth of children. Schizophrenia was observed in three generations in one family.

Children of Schizophrenic Fathers

We observed 17 children of 15 schizophrenic fathers. Slow-progressing schizophrenia was observed only in one 15-year-old boy. The disease began gradually from the age of six with manifestations of obsessions and delusions. Later behavioral disorders appeared, impulsive episodes of anger, and periodic fluctuations of mood. During the last two years autism increased, energetic potential was reduced. The genealogical analysis indicated that the child's father suffered from shiftlike schizophrenia; the father's daughter from the first marriage and his uncle also suffered from schizophrenia. Cases of chronic alcoholism and psychopathy were observed in the family. The child's anamnesis indicated asphyxia during birth and grave dyspepsia in the first year of his life.

In eight children, neurotic disorders were observed. These children were irritable, "nervous," slept restlessly; two boys suffered from nocturnal enuresis. In five children tremor of the eyelids, unstable vegetative disorders, acrocyanosis of extremities, asthenic habitus, some displasticity, and paleness were observed. These children had adequate psychic development. They began to speak early and loved to read. In four, there was a tendency to seclusion and some reticence. The genealogical analysis revealed that in one family a grandmother on the father's side suffered from schizophrenia. In six families there were instances of psychopathy, alcoholism, and suicide.

In four children, delayed mental development was a leading symptom. In two, there were symptoms of the central nervous system (convergent strabismus, asymmetry of face). We attributed a delay in mental development of these children to additional unfavorable factors: in one case the child's father, in addition to schizophrenia suffered from chronic alcoholism; in two cases childbirth was difficult. Heredity of psychotic disorders was established in two families. The remaining four children, whose fathers were schizophrenics, have been normal so far. In three of these families, heredity was not observed.

In the majority of children whose parents were schizophrenic, disorder of physical and psychic development were observed. Childhood schizophrenia was frequent. Consequently, all children born of schizophrenic parents should be observed by a child psychoneurologist. Children of mothers with acute process of schizophrenia should be thoroughly observed and also children in whose families schizophrenia is hereditary.

Mental Health Consultation and Education in Nursing Homes

Fred H. Frankel and Eleanor Clark

This paper deals with an area that is not overtly psychiatric but sorely in need of the skills of the psychiatrist, and one in which he is not often invited to participate—attention to the social and emotional factors in the care of the elderly and chronically ill in nursing homes. One of us spent the past few years as a psychiatric consultant to a project aimed at increasing the understanding of posthospital facilities and improving the care of patients in a group of nursing homes within a large metropolitan area.

An understanding of our experience is incomplete without an awareness of the history of nursing homes. They evolved in the 1930's as a replacement of the almshouse when legislation prohibited persons from receiving social security funds if they lived in government-supported institutions. They provided little more than custodial care. In recent years, FHA mortgages have encouraged improved buildings, but the buildings are changing more rapidly than attitudes or knowledge of the people providing care. These people are, with few exceptions, uninformed about geriatric rehabilitation. They assume that depression is the usual emotional state for elderly people. They know little about dietary requirements and pharmacy issues, and in some instances are casual in their application of basic medical and surgical nursing procedures.

Society and medicine share responsibility with nursing homes for this inadequate care of the elderly population.

Our approach was cautious and exploratory. Nursing homes had attracted public attention and criticism, and we believed that the interest of a teaching hospital could be construed as further criticism. We tried to gain the confidence of nursing and administrative staffs by including them in the discussions. We attempted to meet and talk with the local community physicians, and avoided direct contact with patients.

Because we had no knowledge of the extent to which the personnel were aware of the importance of emotional and social issues, nor to what extent the nurses and administrators varied in their skills, the program was unstructured. The motivation to accept consultation differed from one facility to another. The need to provide good care seemed in some instances to be superseded by factors of curiosity, prestige, or fear of refusing.

Our experience confirmed the fact that awareness of social and emotional factors ranged from impressive in a few directors and administrators to absent in others. When it was impressive, it seemed to be the fortuitous result of factors like intelligence and a well-rounded warm personality. We were struck by the frequency with which poor handling of emotional factors seemed to be associated with unfavorable qualities in the leaders, e.g., inflexibility, poorly disguised hostility, marked insecurity, or mediocrity.

Even gifted nursing personnel had little idea of personality development.

Condensed with permission from the *Journal of the American Geriatrics Society*, 17(4):360–365, 1969.

They needed help in developing insight into the underlying causes of patients' behavior such as hostility, depression, withdrawal, and dependence. They were hampered by the stereotype of the "elderly" and were aided by many physicians who discouraged doing anything new or different with old people.

A psychiatric factor was the lack of familiarity with the concept of verbal expression and ventilation of feelings. The nursing staff tended to deny their elderly patients a continuity with the past, hastily swept aside any potentially disturbing material, and frequently told patients that everything would turn out well. They had difficulty recognizing that dignity was associated with a sense of responsibility and that life without dignity can be hollow.

The following suggestions are made:

Programs should be administered by teaching hospitals or hospitals and clinics affiliated with a department of psychiatry.

Nursing homes should be evaluated and selected on the basis of an interest in learning about these issues. The director should be intelligent, well-trained, warm, and empathic.

Nursing-home personnel should be allowed a say in the schedule, but the organization and control should be in the hands of the teaching institutions.

Poorly motivated administrators or nursing directors should be encouraged to participate by emphasizing the positive value of such a program, but their facilities should not be included until they are ready to make a commitment.

The program should educate nurses who are in direct constant contact with patients. If necessary, a separate program with emphasis on administrative aspects should be arranged for administrators and nursing directors.

Administrators and nursing directors may be able to learn much from a program devoted to the care of patients, but it is doubtful whether many have the educational background or ability to teach what they have learned.

Few nursing directors, registered nurses, or licensed practical nurses know how to recognize an incipient crisis, or to gather an adequate history or sufficient data to present to a consultant. Any program should attempt to present the essentials of theory and well-documented case histories to provide the model for the trainees to follow in the clinical side of the program.

Schools of nursing might be encouraged to develop courses for graduates not yet involved in nursing-home work.

Education and consultation concerning emotional and social issues should not preclude inservice training to improve basic skills in medical and surgical nursing and other areas, and should run concurrently with other programs. Only if combined can accomplishments in physical nursing and in meeting social and emotional needs provide good care for the patient.

On Pop Art, Permissiveness, and Planning

Denise Scott Brown

During the last 60 years, the nonjudgmental, nondirective attitude has influenced the arts, humanities, and even social sciences. Architecture and urban design have felt its impact, and professionals are beginning to look for new, more receptive ways of seeing the environment.

Someone has called the nonjudgmental attitude the greatest invention of the twentieth century. Everywhere it is making inroads; and in architecture, urban design, and planning it works for the better and is much kinder to people.

Perhaps Freud initiated facing the unfaceable. The words "nonjudgmental," "permissive" and "nondirective" relate first to psychiatry. If activities which appear to be "dysfunctional" continue to exist, they must be functional for someone. Levittown, hated by architects and berated by the upper classes, is much of what its occupants want, and architectural diatribes on the uselessness of sociology and the immorality of sprawl won't make it go away.

The same thought in linguistics produced the "nondirective" *Random House Dictionary of the English Language*, followed by an uproar from pedants in the name of the maintenance of standards. The movement has hit political science, education, social welfare, and public health, and in literature there are, among others, Gertrude Stein's effort to "put some strangeness, something unexpected, into the structure of the sentence in order to bring back vitality to the noun," and Tom Wolfe's attempt to evolve a prose style suitable to the description of Las Vegas.

In the fine arts a new horror-giving energy source has been discovered: the popular. This too is old. Yet we are outraged if an architect comes out for billboards or if a planner removes the emotion from his voice when talking of urban sprawl. The first has "sold out to the crassest motivations in our society," and the second doesn't recognize chaos when he sees it.

Planners and urban designers should be leading the way since this vision is so pertinent to design in the city, but it is the moviemakers—for example, Antonioni in *La Notte*, *Red Desert*, and *Blow-Up*—who have investigated the architectural implications of the local scene. TV commercialmakers and billboard designers have stolen a march on architects in the area of the mixed use of words, symbols, and forms to reinforce each other for high-speed communication with a moving public.

Years ago, poets and collagists tried mixing "high" and "low" sources. But we lobby to remove the corner store from the campus, the gasoline station from beside the public building, and the billboard from the landscape. Our architecture becomes tidy, exclusive, and irrelevant. Even the people, where possible, will scurry in "urban concourses," underground.

Action painting, the use of the controlled accident, could re-animate urban design but designers who admire the ordered variety of the architecture of the Dogon or the mill-town miss it in Levittown and design it out of Reston, where nothing is ac-

Condensed with permission from the *Journal of the American Institute of Planners*, 35(3):184–186, 1969.

cidental, not the decorations in the shop windows, not the graffiti cast into the sculpture, and not the careful vistas which say "take my picture."

Architects who buy Op Art should buy Los Angeles. It is the same even, open-ended system with multiple possibilities for the definition and redefinition of focus depending on where you're at. Sometimes the yellows shine brightest, sometimes the blues.

These new, more receptive ways of seeing the environment, inspired by other sciences and arts, are important to architects or planners who hope to stay relevant; and when the artistic fashions move on, we shall still be here because this pop city, this here, is what we have.

This is not to abandon judgment, for planned action implies judgment. Judgment is merely deferred a while in order to make it more sensitive. Liking what you hate is exhilarating and liberating, but finally reaffirming for judgment.

Architects and urban designers have been too quickly normative. Where the facts and intangibles are many, a mystique or a system—a philosophy of Man and the Universe or a CIAM grid—may substitute for the collection of facts or for hard thought. This makes them poor scientists and, strangely enough, indifferent artists as well. Social scientists have been the opposite: measuring trends while Rome burns, sniffing at other people's "values" when they should be recommending new norms for a new society. But all this is coming to an end. Architects and social scientists meet today in many fields, from social protest and advocacy to the analysis of the mass culture and its artifacts. Citizens groups retain advocate architects and urban designers as well as advocate planners, and even in Europe where early "modern" architectural authoritarianism is still strong, architects and urban designers are learning to put Los Angeles and Las Vegas on their travel itineraries as well as the denser areas of Manhattan.

Young architects who confront social issues often abandon architecture and urban design, frustrated by their irrelevance to real urban problems. They embrace social or systems planning, or projects which demand social and communal concern rather than professional service. This is wasteful and unnecessary. The best thing an architect or urban designer can offer a new society, apart from a good heart, is his own skill, used for the society to develop a respectful understanding of its cultural artifacts and a loving strategy for their development to suit the felt needs and way of life of its people.

Creative Learning in Children's Playgrounds

ALEXANDER GREY

Play of children and youth emulates in its own special way the world they will inherit. The complex technological world of today demands from and stimulates in children more complex play activities than ever before.

The wide open spaces, rolling country, bush, and beaches—places where rural children play—are ideal places for observing and listening to children. With the fundamental materials, the natural media, available to them, children give adults clues of the *what* and *how* of their play. City and town playground and recreation center planners can get fresh inspiration for creating playground equipment from rural children.

The city needs to restore its life blood by drawing upon the country for ideas. City children need the fundamentals from which to begin the process of coping with and contributing to the carpentered world in which they live. By the same token, the country's need is to find ways to bring to children's play more awareness of the requirements for a technological age. This is a total program for rural as well as city dwellers.

In a world where more people live closer together, space gives way to dwellings. Becoming cramped in the world, people seek places where they can explode and feel themselves expand.

Effort is needed in this technological age to do more in less space and cater more completely to people—especially the young. Playground planners need to look again at those for whom they are planning—the children. This planning begins in the everyday business of living and flows over into the playground.

How can the paths children walk be designed to suggest varied actions other than merely walking? Colored pavement slabs in a variety of shapes and areas—some irregular, others regular, still others visceral in pattern—lend themselves to more fanciful journeys.

How can shopping areas be made to appeal to children? Possibilities are flower borders raised at various levels, shafts of colored light reflected on the pavement, walls with holes and with mirrors, handrails of varied thicknesses and textures, sculptured shapes and "totem" poles on which to lean and in which to recline and chat with others.

How can walls and concrete or steel bulwarks be constructed for children's adventurous and safe climbing? Suggestions are recesses at different heights in garden areas; shapes for curling up, hiding and reflecting; shapes for climbing and jumping.

The playground is the test for adult planners. Here the planner has to provide adaptable equipment. He wants equipment that is planned by adults who understand children, that moves away from barren, threatening, sterile, unimaginative equipment, away from fixed shapes like concrete pipes, simulated animals, dangling wooden swings, narrow slides. Why *away* from these? Again, consult children. Observe them passively repeating the effects of the solitary slide and the swing. Observe them confronting a fixed monster in concrete, a pipe, or

Condensed with permission from *Childhood Education*, 45(9):491–499, 1969.

an animal shape. There is little they can do but get on or in, crawl under or through. Thereafter all action is mechanical. Children become passive when confronted by a nonchallenging world they cannot help shape. Such a world represents a threat. It says, "You are impotent." Observe children on a jungle gym—all rungs. The same size, the same horizontal and vertical distances apart. After the first effort, all future efforts are repetitive, empty of adventure. "Fun" comes from getting to the top and keeping the other fellow down. Mastery of other children, not of the environment, is implicit.

Places or spaces for play can be planned to be free of threat, better than passive, released from stereotypes. They can be planned to induce effort and to stimulate thinking. They can lend themselves to leadership, followership, sociableness. They can open the way to adventure and challenge, adaptability and creativeness. They can bestir in young people latent qualities of harmony and beauty.

The kind of planning that lies behind the achievement of such a use of space includes a range of demands from people in the community. Some want to take part in their children's enjoyment. Others want to enjoy the activities of busy children and to feel pride in the preservation of the natural features of their community.

Wherever a tree can grow or any of the earth's raw materials can be preserved, earth's inhabitants feel more at home and at ease. The rooting of the tree in the earth that supports it symbolizes man's search for a base to support himself. The quest for such support is intensified as the crowded loneliness of depersonalized living creeps forward. We live today in carpentered environments, concreted and bituminened, inches above natural raw materials and we are left having to find how to establish oneness with nature.

In some districts it is still possible to preserve or reestablish the rugged beauty of nature in rocks, trees, and streams. Sensitivity to preserve a rock outcropping, a tree, or the meander of a stream is the kind of planning that can suggest to children further imaginative play uses for these media.

Concrete—a hard, rugged, tough medium—does not have to be brutal. It can be made to flow esthetically and it can be molded with mathematical and esthetic precision. The proportions can demonstrate to the eye and the body as they slither over the multiple surfaces examples of the golden mean and of mathematical progressions that are also found in the whorls of a nautilus or a snail shell, the seed spirals of a pine cone, the intricate patterns of a tree's branches. Planners can be influenced by these examples of nature's symmetrical bases for apparently asymmetrical effects in the total structure.

These plans incorporate the wherewithal for the climbing, swinging, sliding, getting into activities of all those who are physically alert. But the physical is no longer an end in itself. It is incidental to the more satisfying, adventurous, esthetic experiences. Climbing a tree is more of a challenge than climbing a jungle gym. Every angle, every limb, every step has to be negotiated with the tree—a personal transaction between the climber and the tree. The climber sees the tree in a way he can never see a jungle gym, for the experience of climbing a tree is not simply physical—thought and perception, puzzlement and discernment are demanded in every step.

It next behooves the planner to ask

what additionally (e.g., leadership, followership, and sociability possibilities) can be planned into such items as slides and swings. Can these items be constructed so as to provide children and youth with suggestions that will lead them to wider and more developed relations with their world? Just as the ski course is determined by the mountain, could not slides be erected that are a function of the inspiration that originates the concept "slide"? We tried to do this in a bush area where the natural form of a multi-child slide grew out of the shape suggested by the graceful lines of the Tui, a bird native to New Zealand.

There is need to find a place where children scale down to their size the world of speed by which they find themselves surrounded. A realignment of their perspective is possible when they can create and control the fantasy of their speed world. Better than the discards of cars, engines, and airplanes are light, movable, permanent materials such as box and oval shapes in which they can tumble to act out their fantasy of movement.

Perhaps one of the most important requirements is that of providing adaptable pieces of equipment. As much playground equipment as possible needs to be movable and adaptable. The skill of the planner is taxed here because movable pieces introduce difficulties. They need to be steady items, balanced, light, yet stable and durable, for which properties further experiments with plastics, rubber, foams, concrete admixes are needed.

The presence of adults who can learn to supervise in play spaces with movable pieces of equipment is an approach that has increased awareness of the need to find means by which we safeguard provisions for adventurous play. With supervisors present, many more activities become possible: puppets, pottery, carpentry, engineering, spinning, weaving, archaeological digs, play acting, creative dance, sculpting, and carving.

Where supervisory services are not available, there is still scope for more adequate equipment. Planners need to consider the use of color. Light, shade, contrast, preferences, densities, and relationships of color are omissions in our outdoor play areas. Where strong earthy reds are used, we have found children's play interest heightened. Yellow ochre, equal in density to balance the red, is preferred to garish greens and oranges. Such colors as reds and yellows heighten other materials, as well as the surrounding greenery and masonry.

Through changes of playground equipment, planners have one means of broadening the social base of communities. With continual, versatile planning, children's playgrounds can become a focal point of progress for each community and an asset for creative learning by today's children for tomorrow's world.

A Community-Based Residential Program for Disturbed Children

A. J. Montanari

Despite the great quantity of literature about residential treatment of emotionally disturbed children, the field remains experimental. The common factor is costliness. At the Montanari Clinical Center, we have tried to develop a pattern that is both effective and economical. Our children range in age from 4 to 20 and have been called "the kids nobody wants." They run the gamut from severe behavior or character disorders to prepsychosis and childhood psychosis. Some are organically damaged; most are functionally disturbed.

Our consultant chief of psychiatry has characterized them as children who have great difficulty in controlling their impulses, in learning, and in getting along socially. In spite of these special needs, or because of them, we treat the boys and girls in the community itself. We have found that to be the key to reaching and teaching them.

The children live in 17 white, air-conditioned cottages scattered throughout Hialeah's residential area. The only thing that distinguishes them is bright red doors, to help the youngsters identify them.

Our location makes it possible for the children to go to neighborhood stores, theaters, library, local swimming pools, parks, churches, and, when they are ready, public elementary and secondary schools. As soon as possible after a child enters the center, he is introduced to the local people he will be in regular contact with—the policeman, the neighborhood barber and merchants, lifeguard at the swimming pool.

The community setting is important to our goal of social education. We strive to help our youngsters tolerate stress, social as well as emotional, and to develop more appropriate social skills and insights. By having the learning take place in a real community, we make the lessons pertinent and immediate, and the children more quickly learn the need to interact acceptably with their environment.

At times we encountered community resistance, not because of any major incidents but merely because our children are "different." The resistance has crumbled, and many local children have been rehabilitated. Nevertheless, we supervise the children carefully to spare them unfavorable incidents. The task is compounded because we have no locked doors and no "quiet rooms."

Our setting is therapeutic, but the clinical aspects do not show. Cottage interiors are functional. We avoid having showy but fragile objects to avoid the guilt that would follow the inevitable breakage.

Orderly surroundings are important for severely handicapped children. They must be taught to get along in a household, not only by caring for their own needs but by relating comfortably with other people. Every child has his own bed, clothes closet, dresser, and place at the table. We encourage the children to become as independent as possible. Houseparents and teachers

Condensed with permission from *Hospital & Community Psychiatry*, 20(4):25–26, 1969.

do nothing for a child that he can do for himself.

Each cottage houses eight to twelve children and is staffed by three houseparents. That ensures stable and continuous care for the children, since at least one houseparent is always present. We have houseparents of both sexes in all cottages except the one for older girls. We avoid hiring married couples, because it is hard enough to find suitable individual men and women, let alone two who are married to each other.

Our staff are selected more for personal than technical qualifications. We look for competent, devoted, warm human beings. Some are part-time students working toward a degree; some lack a minor requirement for certification in their field; some are short on technical background but long on humane qualities.

All staff, including administrative and maintenance employees, are urged to take a personal interest in the children. Sometimes we find that a janitor or a cottage maid has the best rapport with a child, and arrange for them to have time together to develop the relationship. In such cases, the employee attends staff meetings.

We use a minimum of written directives and standardized procedures. We communicate in person, keep an open mind to suggestions, and reward effective innovations with respect and appreciation.

Flexibility does not mean vacillation or unbounded permissiveness. The children are not forced to face immutable demands, are not told "do it or else." In some cases, a staff member may negotiate good behavior with a child, while helping him understand what the socially acceptable limits are.

Flexibility also means that staff members step in wherever needed. For instance, a teacher may walk a group of children back to their cottage after lunch if the houseparents are occupied elsewhere. Inservice training is an ongoing process, and we all learn from each other.

Stability is an important part of the environment; too many of the children have previously been treated in an indecisive contradictory manner. They realize that when we say "yes" or "no" we mean just that; they always know where they stand and what is expected of them.

The children's sense of security is strengthened by our policy of permitting them to contact a member of the staff at any time. If a frightened child awakens in the middle of the night and feels that only I can comfort him, the cottage staff calls me. That seldom happens, but it is a solace to the child to know that the help he wants is immediately available.

Informality is an integral part of our approach. A psychiatric interview is likely to take place at the drugstore over a banana split, or under a palm tree in the back yard.

Visitors are always welcome; no appointment is necessary. We encourage local citizens and children to associate with our children, for we believe that such contacts are healthy for both sides.

Treatment begins as soon as a child enters the center. We greet him with a welcoming party, not a series of interviews and tests.

The treatment plan for each child is individualized and altered to meet changing needs and abilities. Progress is reviewed at sessions attended by the key professional staff and personnel immediately responsible for the children's care. Those sessions augment the day-to-day communications between

staff members on all levels and help us continually reevaluate our treatment approaches.

Most children are enrolled in the educational program, which is structured as three schools, each with a principal. Each school has eight or ten teachers, responsible for five to eight children each. The teachers are assisted by school aides, who handle the more routine matters, such as clerical reports, errands, and toilet-training.

The principals are supervisors, but they move into a classroom to help teachers when necessary. The overall educational program is coordinated by the director of education, who works with the principals and teachers to provide the most effective and therapeutic instruction. The classes include occupational therapy and speech therapy as well as academic subjects.

In the classrooms and cottages, the children are grouped by their potential for therapeutic interaction, and to a lesser degree by their age and degree of handicap.

By age 10 or 12, many children begin spending some time in the workshop. By 16, they may be assigned to the prevocational program. About a dozen older students work with our maintenance department, learning such trades as carpentry, tiling, painting, and cement-finishing.

When a child matures and improves enough that we start planning for his return to his family, we involve him increasingly in community activities.

Another important part of our program is family counseling. It starts on the day of admission and continues until discharge. Many parents have emotional problems concerning their child's handicap, but we do not probe deeply into them. We feel we can best help the parents by helping their children, and we usually find that as a child improves, his parents do also.

One goal is to provide treatment as economically as possible. That has become difficult with the rising cost of living, and in the past few years, expenses have gone up nearly 50 percent. Currently it costs about $15 a day to treat and care for a child, including providing him with food, clothing, shelter, and spending money. Only about a third of our budget comes from parents' payments; the rest is covered by insurance payments, donations, and agency contracts. We have contracts with about a dozen States to treat children for whom they have no suitable resource. We rely heavily on donations to our scholarship fund, sought mostly through fund-raising events. Occasionally we receive donations from parents whose child we have rehabilitated. Our costs cannot be compared with those of State institutions, because we pay taxes and have expenses that they do not.

We will continue to try to provide treatment at the lowest cost possible, by focusing on the necessities. The unaffordable luxuries include having physicians as full-time staff members rather than as consultants, more personnel with graduate degrees, formal research programs, and fancier surroundings. Except for the first item, I do not think those things are so important, and indeed might even dilute the center's spirit of dedication.

Behavior Modification of an Autistic Child

Eleanor R. Brawley, Florence R. Harris, K. Eileen Allen, Robert S. Fleming, and Robert F. Peterson

The child with early infantile autism presents one of the most difficult treatment cases. In recent years, techniques derived from operant learning principles have had some success. This study was designed to extend operant learning techniques as therapy for an autistic child.

The subject, Steve, was a 7-year-old boy. Both parents were college graduates, the father a professional man, and both seemed to be warm, responsive people. At the time the study began, Steve was difficult to handle in the home. He did not play with toys, had severe tantrums and crying episodes, rarely spoke, ignored the parents and family members, and did not seem to discriminate one member of the family from another. Steve's behavior on the ward was extremely withdrawn. He handled materials and toys infrequently. He would repeatedly slap himself about the face and head, crying loudly while doing so. He also displayed bizarre body and hand movements, as well as spitting, and licking the wall.

The study began with a selection of behaviors to be strengthened or weakened.

Appropriate behaviors were: verbalization—enunciation of a comprehensible word or words; use of material—use of materials as they were intended to be used, for example, riding a tricycle, looking at a book, following a request or command. Inappropriate behaviors were: self-hitting, junk verbalizations, withdrawal, and tantrums.

Social reinforcement was defined as one or more of the following: touching the child, being within two feet of and facing the child, talking to, touching, assisting, or going to the child.

The behaviors of child and adult were observed, coded, and recorded during successive 10-second intervals of each session. The study was divided into four phases, a baseline and first reinforcement period, followed by the reversal and second reinforcement periods. During the baseline period, behaviors of child and staff were observed and recorded while they were interacting on the ward.

The first reinforcement period consisted of 21 sessions over a 10-week interval. During the first sessions the therapist checked the reinforcing effectiveness of foods such as potato chips, ice cream, candy, etc. Potato chips seemed most desired. The therapist thereafter presented praise and a potato chip simultaneously following desired responses. In subsequent sessions praise was used continuously while food was delivered on a variable basis. During a new task or whenever the child's response appeared to be particularly appropriate, the child received both food and praise. Concurrently, the therapist turned away and did not look at or speak to him whenever and so long as he emitted behavior defined as inappropriate.

Because Steve evidenced interest in music, the first session began with the therapist singing and playing an autoharp. This activity continued as long as Steve appeared to attend to it. If he engaged in bizarre behaviors, the

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singing stopped and the therapist turned away. Later in the session the therapist engaged Steve in concrete tasks such as blowing soap bubbles, tracing shapes, and clapping hands.

During the second session Steve was presented with a notebook containing teaching materials to be used at the table during the first half of the session. During the latter half, play materials were presented and play skills emphasized. The time spent in the experimental room was increased until by the sixth session Steve remained for one hour, spending the first half hour seated at the table across from the therapist working on the language and reading materials and the second half working on play activities.

To stimulate verbal responses, the therapist worked to develop attending and imitating behaviors. Presentations were programmed from imitation of gross actions demonstrated by the therapist to mimicking sounds and then words she enunciated. Soon Steve was able to mimic names of objects and pictures, colors and shapes, and finally phrases and sentences. His speech soon included immediate and correct identification of primary and secondary colors, circles, squares, triangles, rectangles, and ovals. He then progressed to sorting colors or shapes, verbalizing each name as he did so.

Steve responded so well to the visual discrimination tasks that letters were presented for matching. Within two-and-one-half weeks Steve could name without error both the upper- and lower-case letters of the alphabet. Pictures of things were then presented for naming. On several occasions he named other words that began with the sound, without receiving a visual cue from the therapist. The printed words were then presented without the picture. Finally, Steve was reading short sentences. Writing was worked on later since Steve had hardly held a crayon in his hand before.

During the second half of the session, Steve was directed to engage in activities such as situps, hopping, skipping, throwing a ball. Next he was instructed in the use of fingerpaint, clay, crayons, and cutting and pasting. The therapist demonstrated, made suggestions and reinforced Steve for the appropriate use of each material.

If Steve engaged in tantrum behaviors he was isolated in a nearby room until he was quiet for a two-minute period.

To determine whether the reinforcement operations were a significant factor in the development of Steve's acquired verbal and motor responses a four-day partial reversal of the reinforcement contingency was carried out. It was deemed undesirable to reverse all of his new behaviors because of the severity of Steve's problems. Appropriate verbalizations were given no reinforcement. Inappropriate behaviors were now reinforced.

Continuous social and intermittent primary reinforcement was again instituted for five sessions.

During the baseline sessions appropriate behavior averaged 28 percent and inappropriate behavior averaged 46 percent. Inappropriate behavior received approximately twice as much attention as appropriate behavior.

On the first day of reinforcement procedures appropriate behavior rose to 68 percent, an increase of 46 percent over the last day of baseline. Total appropriate behaviors ranged between 50 percent and 80 percent

throughout the reinforcement period, averaging 70 percent.

During baseline, appropriate verbalization averaged 2 percent. There was an immediate increase to 10 percent on the first day of reinforcement followed by a jump to 40 percent on the sixth day. The percentage of appropriate verbalization continued to increase averaging 46 percent per session in the eight sessions prior to reversal.

On the first day of reversal appropriate verbalization decreased to 20 percent. It dropped to 16 percent on the fourth and last session. When reinforcement was resumed the percentage rose immediately to its former level of 47 percent with an average of 47 percent during the second reinforcement period.

During the baseline period, withdrawn behavior occurred an average of 25 percent of the time, with a high of 36 percent during the last session. With the inauguration of extinction procedures, withdrawn behavior immediately dropped to less than 1 percent and did not occur again.

Steve's rate of self-hitting averaged 15 percent during baseline, with highs of 20 percent in two sessions. Self-hitting was subsequently reduced during the extinction procedures to an average of 3 percent. During the reversal period when self-hitting was again followed by attention, it averaged 5 percent with one high of 10 percent. In the second extinction period, it averaged 3 percent, varying between zero and 5 percent. The intensity of self-slapping diminished considerably; often they were no more than gentle pats.

Junk verbal responses averaged 10 percent during baseline and did not show the erratic variability of the self-hitting behavior. Junk verbal behavior also dropped on the first day of reinforcement. By the sixth day of reinforcement it had decreased to less than 1 percent and it remained stable. It increased slightly during reversal but dropped out with the return of the extinction procedures.

Tantrum behaviors during baseline averaged 3 percent. These behaviors did not reappear during the treatment sessions and were reported to occur less frequently when Steve was on the ward.

Followup data were obtained in a three-month period. During this time the therapist continued working with Steve to expand his newly acquired behaviors and to increase his interaction with other children. Post checks taken during eight sessions showed that appropriate verbal behavior remained in the 40 to 50 percentiles, with total appropriate behavior in the 60 to 70 percentiles. Inappropriate behaviors remained under 5 percent. Following this period Steve was discharged from the hospital to a special school where he has remained in attendance.

Child Behavior Therapy: A Community Program in Appalachia

ROBERT G. WAHLER AND MARIE ERICKSON

Community psychology is a popular concept in mental health. It implies that the clinician should concentrate on the patient's environment rather than on the patient per se. The clinician's role should be that of an agent for change in his client's community—client's relatives, friends, and working associates as well as the more impersonal aspects of his social and physical surroundings.

While a number of models could be employed to implement the concept, one is of particular relevance. Reinforcement theory has as one of its basic tenets the assumption that the development and maintenance of behavior is a function of stimulus contingencies set by one's environment. Man behaves as he does because of differential reinforcement, provided primarily by the attention of other people. In the case of the child, parents, peers, siblings, teachers, etc. are selective dispensers of social attention; these social agents "teach" him which aspects of his behavior will be most instrumental in obtaining approval, reassurance, affection, nearness, and other forms of attention.

Pineville, Kentucky is the county seat of Bell County, and the location of the Bell County Health Center. This clinic is state supported and serves the medical and psychological needs of residents in Bell County and Harlan County. The staff of the psychology unit is made up of one permanent member, (a social worker) and one consulting member (a clinical psychologist) who visits the Clinic twice a month.

Ninety-five percent of the referrals to the clinic are children. Presenting complaints range from retardation and autism to less serious problems such as low achievement motivation in school settings. The clinic charges no fees.

It was obvious that a clinician would find it difficult to work therapeutically with patients, much less handle a large waiting list of prospective patients, on such a basis. Therefore, it seemed advisable to consider a program which emphasized the use of nonprofessionals.

Within a period of two months following a community effort to recruit workers, 19 volunteers were available. Six were public health nurses, three were public assistance workers, and four were citizens engaged in other occupations. Several teachers and school counselors assisted on specific cases.

Training was primarily of an in-service type. When a prospective child therapy case was seen at the clinic, the child, his family, and any other closely involved people were interviewed by the professional staff. The interviews were aimed at obtaining descriptions of the behavior which created problems. Efforts were made to determine the usual consequences of such behavior.

A volunteer worker was then introduced to the interview data by the clinic psychologist. Discussion emphasized descriptions of those responses which were considered deviant. The clinician emphasized the notion that

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the behavior was probably being maintained by people in the child's environment. Then followed a brief essay on reinforcement theory.

Prior to step 3, the volunteer obtained at least two 1-hour observations of the child's behavior within the problem setting. Second interviews were then scheduled for those social agents who seemed to provide clear and modifiable contingencies for the child's deviant behavior. The volunteer and clinician conducted these interviews together. These social agents were given descriptions of the child's deviant behavior and advised that their attention to such behavior was a likely cause of their maintenance. The social agents were told to ignore the child's deviant behavior but to respond as usual to his other behavior patterns, especially those which seemed incompatible with the deviant behavior. Where the deviant behavior involved aggressive or oppositional actions, a suggested punishment procedure was social isolation. It was then made clear to the social agents that the volunteer would make weekly visits to observe interactions between them and the child and point out needed corrections in social contingencies.

The major claims of the program's effectiveness rest on reports of improvement by the volunteers, the number of cases seen by the clinic, and the time spent treating these cases.

Observational data were collected as follows: after a volunteer became familiar with the behavioral problems presented by her case, she was introduced to a checklist method of recording behavior. This method required the observer to make coded checks for the occurrence or non-occurrence of the problem behavior and the stimulus contingencies, within successive 20-second intervals. For each case, the worker obtained two 1-hour observations prior to treatment and two 1-hour observations just after termination. These observations were made in the child's home or classroom or both.

It proved possible to classify the problems in five categories: classroom disruptive behavior—fighting children, shouting, and not obeying instructions; classroom study behavior—attending to the teacher or to learning materials; school absences; home disruptive behavior—fighting, destruction of property, and not obeying parent instructions; home study behavior—attending to homework materials.

Many of the 66 cases were deviant in terms of more than one category. After treatment all categories displayed marked changes in the therapeutic direction. Unfortunately, a control group was not included to evaluate the causal influence of treatment procedures. Thus, although the children did show improvement, the role of the volunteers in producing the improvement is not clear.

Although no great emphasis can be placed on the correlational improvement data, results based on the number of cases must be considered compelling. In terms of efficient use of the professional clinician's time, such a community program has much to recommend it.

Contraceptive Steroids and Sexual Activity

Richard P. Michael and T. M. Plant

Studies on the sexual behavior of higher primates with compounds used for oral contraception have relevance for humans.

Two mature female and four adult, sexually active, male rhesus monkeys were investigated for 14–17 months. Each female was paired with two different males. The females were introduced regularly into large testing cages occupied by a male for tests of 60-minute duration. Each pair was tested 2–3 times per week, and between tests animals were housed in the same room in individual cages without access to each other. To prevent pregnancies during the pretreatment period, the Fallopian tubes were ligated.

After one or more month's observation without treatment, each female received daily .05 mg mestranol and 1 mg ethynodiol diacetate for 21 days, followed by seven days without treatment when the cycle of treatment was repeated. This routine was maintained for 6–7 months, when it was changed to a sequential regimen consisting of .05 mg mestranol for 11 days, then .05 mg mestranol with .75 mg chlormadinone acetate for the next 10 days, followed by seven days without treatment; this routine was maintained for 4–6 months. The schedules of treatment were similar to those recommended for human contraception.

There was a marked decrease in the mean number of ejaculations in three of the four pairs when both combined and sequential treatments were compared with normal menstrual cycles. In three pairs, also, the depression of ejaculation was somewhat less marked during the sequential than during the combined treatment regime. The total number of intromitted thrusts occurring before ejaculation provides an additional measure of male sexual performance in those tests in which ejaculation is not abolished. When ejaculation times are short and stimulation of the vagina is optimal, the number of thrusts required for ejaculation is lower.

An increase in the mean number of thrusts to ejaculation occurred in all pairs during treatment with contraceptive agents; this effect was more marked with ethynodiol. When the effects of successive cycles of treatment on the behavior of individual pairs were examined, differences emerged between the two treatments that were less obvious in the group data. With mestranol-ethynodiol, both the depression of ejaculation and the increase in thrusting changed with successive treatment cycles, and in one pair during the seventh month of treatment, ejaculation occurred only once in twelve tests while the thrusts required to achieve it had trebled. With mestranol-chlormadinone, the impairment of ejaculation was not obviously progressive and thrusting remained unchanged.

Data from infra human primates cannot substitute for clinical evaluation, especially for human sexual behavior, which is influenced by subtle social and cultural factors. But the possibility should not be overlooked that prolonged medication with these steroids may modify human sexual behavior, in particular that of the male by influencing the hormonal status of his partner.

Condensed with permission from *Nature*, 222 (No. 5193):579–581, 1969.

The Emotional Impact of Surgical Sterilization of the Female

James L. Mathis

Since advances in medicine have reduced the number of organic indications for surgical sterilization, there is a relative increase in elective sterilization for socioeconomic reasons. One result is that the psychological aspects of gynecological surgery have assumed greater importance. Approximately 4 percent of women undergoing hysterectomy will become severely depressed. Lesser degrees of disability may be of equal importance to the patient and her family.

Historical data are profuse in their testimony on the emotional importance of the uterus and its reproductive significance. For unnumbered centuries the worth of the female depended upon her sexual function. She was of worth as an object for the entertainment and sexual gratification of men, but the majority of females were marketable only for the ability to reproduce. This factor was so significant that the medical profession of the ancient Egyptians discovered methods of determining a woman's fecundity. One method was to place a piece of garlic in the vagina. The odor would be detectable on the breath of a fertile woman within 12 hours. In another test the woman squatted over a mixture of date flour and barley beer. The fumes would produce nausea and vomiting in the woman who was able to bear children.

The Kahoun papyrus contains 17 prescriptions concerning female sterility. Some degree of control was needed, however, and the Ramesseum papyrus gives a contraceptive prescription primarily composed of crocodile dung.

The early Greeks did not doubt the emotional significance of the uterus. Wandering of the uterus was thought responsible for most female emotional disorders. The evolution of medical knowledge led to some change in the 17th Century. "Malady of the vapors" became a complaint of fashionable ladies. It signified hysterical symptoms caused by the spreading of noxious substances emanating from the uterus. This relationship between hysterical symptomatology and the uterus was so ingrained that medical authorities derided Charcot when he reported a case of hysteria in a man. Only the work of Freud and Breuer laid to rest this concept, and yet, as in most instances of mythological thinking, behind it lay a grain of truth.

This grain of truth is that the basic value of the female is founded upon the ability to reproduce. It may be that sociological changes will alter this, but it is not yet so. There remains much about the reproductive drive and its control which we do not understand. Within the many bits of evidence and generalities there is one definite fact: each woman must be individually assessed before a prognosis can be made. This assessment must include the indications for, and the patient's attitude toward the proposed surgery, previous personality characteristics with special attention to responses to losses and the ongoing family situation.

Sterilizing surgery demands a concrete indication which may range from socioeconomic difficulties to an advanced malignancy, and some of

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the emotional impact will be determined by this indication. Some manifest anxiety is healthy, but too much or too little may indicate postoperative difficulties. An assessment of each case must include the knowledge that the female may conceptualize her uterus as having four functions: reproductive, menstrual, sexual, and as a reservoir of strength and effectiveness.

The major preoperative concern of the woman facing sterilization involves a loss of child-bearing ability. The attitude toward having children is not an ironclad indicator of underlying feelings. Some women who desire no more children and who are aware of realistic disadvantages of conception may need the ability to conceive in order to feel complete and feminine.

The opposite woman is the one who has accepted a complete repudiation of femininity. To her, the uterus may represent a foreign body whose removal can result in increased well-being.

Most women view menstruation as an essential part of the female physiology. To some it is a cleansing function, to others a physiological calendar. To almost all women, it is a symbol of femininity and womanhood. The woman who feels less secure about her feminine identification will most need this symbol, and the need is unrelated to the presence or absence of pain and discomfort.

Many women fear the lessening of sexual desires and abilities after a hysterectomy. Of equal importance is the fantasy that their husbands will find them less desirable. In one study of women severely depressed following hysterectomy, the husbands actually had rejected their wives. The actual sexual disturbances which occur are not uniform, but are related to irrational fears and beliefs concerning the loss of this valued organ, and are therefore secondary to psychological rather than anatomical effects in most cases.

Women are seen postoperatively who act as if the uterus had been a reservoir of energy. This may be a combination of denial and displacement, and the fears actually are concerned with whether or not they will be able to carry out their sexual activities and remain desirable to their mates. Part may come from ideas about what happens to castrated animals. Castration and sterilization are synonymous in the minds of many patients.

This part of the evaluation also means a consideration of the etiology of the primary condition. Disease or injury of the genitals may be viewed as punishment for errors, frequently of a sexual nature. There are probably few women who have not done, either in fantasy or in reality, something for which they could feel punishment was warranted. It behooves the surgeon to delve at least superficially into fantasies the woman might have about the indications for surgery and to allow these fantasies free expression.

The physician must ask about the patient's emotional history, especially separations, deaths, diseases, operations, etc., and how the woman reacted to them. Nothing so well predicts depression as a history of depression.

A sterilizing procedure rarely is an operation involving only the woman. The male enters the picture in two ways: the woman may have fantasies of how he will react to her, and the man may have fantasies and thoughts about how the woman will be affected. It is important to allow each

to express these fantasies, and then, and only then, correct misconceptions and fallacious attitudes.

Included in this topic are the reality factors of parity and age. The loss of reproductive capacity may be a blow to a 25-year-old mother of one child, but a blessing to a 38-year-old mother of six. Even so, the physician must not allow the reality factors to lull him into ignoring the significance of the surgery to the older patient or to the grand multiparous one.

The question arises whether to do a hysterectomy or tubal ligation on the premenopausal female. Hysterectomy produces the loss of part of the body, while tubal ligation produces only loss of function.

An elective tubal ligation is less apt to produce a disturbing emotional reaction than a hysterectomy. Fantasies of pregnancy are important to the female for six to twelve months postoperatively. These fantasies allow the working through of the loss syndrome without the production of severe depressive symptomatology or other emotional upsets. The loss of the uterus and menstrual function make it more difficult to maintain these fantasies without becoming aware of their absurdity. Tubal ligation patients not only can maintain the fantasy, but many feel that the procedure could be reversed if they so desired.

Many adverse reactions, especially those occurring with elective tubal ligation, are compounded by a sense of guilt which is not so severe when the woman feels that the surgery was unavoidable. This reaction can be lessened if the surgeon does not simply present the facts and request that the woman make the decision, but rather, presents the facts and then advises a course of action. It remains the woman's decision, but the average patient's reliance upon an authority figure's advice will negate this point.

The psychological assessment of the patient begins at the moment of patient-physician contact. Even when organic pathology dictates the choice of the surgical procedure, a total assessment will be necessary for the proper preparation and aftercare.

A choice of procedures must be made when the surgery is for purely contraceptive measures. The surgeon must evaluate the patient and base his decision upon reality factors which include age and parity, plus how greatly he feels that the patient needs the function of menstruation and the possible pregnancy fantasies. An inflexible policy appears no more logical than deciding that all deliveries will be performed in exactly the same manner.

Psychosomatic Aspects of Symptom Patterns Among Major Surgery Patients

STEPHEN M. WEISS

What are the psychiatric/physical symptom relationships among major surgery patients as compared with findings with other patient groups? And do men and women react differentially to the stress of surgery?

A sample of 54 patients awaiting major surgery at the University of Oregon Medical School was administered the Cornell Medical Index and the Taylor Manifest Anxiety scale as part of a psychological study of surgical patients.

Patients having illnesses involving presumed psychosomatic correlates were excluded, as well as patients having a history of any diagnosed psychiatric disorder or psychiatric treatment.

The results showed that endorsement of psychiatric symptoms is highly correlated with acknowledgement of physical symptomatology. Anxiety level, as measured by the Taylor Manifest Anxiety scale, is significantly correlated with expression of physical as well as psychiatric symptoms.

The relationship between (*a*) physical and psychiatric symptoms and (*b*) psychiatric symptoms as related to anxiety level have different meaning for the two sexes. The relationship between psychiatric and physical symptoms appears confined to female major surgery patients. However, a significant relationship exists between physical symptoms and anxiety level among male patients, a finding not reflected in the results of the female group. The findings suggest that the sexes deal with the stress of illness and surgery by quite dissimilar mechanisms.

Women apparently have available a sizeable emotional repertoire for coping with the imminent threat surgery poses to their self-integrity. Anger, fear, tension, and depression appear to be culturally acceptable means of relieving concern in the form of "catharsis."

Men do not have the same avenues of expression available to them. The male in our society is expected to "grin and bear it," keep a "stiff upper lip," "don't let it get the best of you." Hence, the male patient must use the more circuitous route of expressing feelings in terms of the most logical alternative: increased preoccupation with bodily processes. Rather than expressing how he feels (e.g., depressed, anxious, frustrated), he is likely to have a recrudescence or intensifying of earlier physical problems or give birth to yet untried symptoms as an expression of his level of discomfort.

It would appear that both sexes are expressing similar concerns, but in different "symptom languages." Although both languages suggest a desire for attention, comfort, and solace under stressful circumstances, the "camouflage" of the male surgical patient may create considerably more pre- and postsurgical difficulties for both himself and the professionals responsible for his care.

Condensed with permission from the *Journal of Psychosomatic Research*, 13(1): 109–112, 1969.

Programed Learning, Teaching Machines, and Dyslexia

BERTRAND G. WINSBERG

With the augmentation of technological sophistication, burgeoning of computerized teaching machines has occurred. The economic magnitude has been expressed in the Congressional report, *Automation and Technology in Education*, where it was stated, "The American economy was built around the railroads in the last half of the 19th century, around the automobile the first two-thirds of this century, and it will be built around education in the balance of this century."

An instructional program has been variously defined, and some disagreement exists. One definition states that a program "is a vehicle which generates an essentially reproducible sequence of instructional events and accepts responsibility for efficiently accomplishing a specified change from a given range of initial completeness or behavioral tendencies." The key words here are reproducibility, sequence, and efficiency, for these comprise the suggested criteria for program assessment.

The sequential instructional events are referred to as frames. The probability of selecting the correct response may be facilitated by incorporating clues into the content of the frame. These clues are called either "cues" when they are within the context of the frame or "prompts" when they precede the frame. This is a rarely used distinction; cuing and prompting tend to be used interchangeably.

After responding to a frame the student is immediately notified whether his answer is correct or not. This factor plus the design of programs so that the error rate is small is said to be reinforcing when it facilitates retention of the material learned and increases the likelihood of the student continuing to select the correct response.

A program may present frames in two ways, linear or branched. A linear program involves a succession of instructional events without omitting any items, while a branching program allows the student to strengthen areas of insufficient knowledge by providing miniature programs for certain frames. Programs may also be multiple choice. In this form the emphasis remains on immediate awareness of errors. Multiple choice programs are not so widely used as constructed response programs.

Teaching machines involve the use of automated means of presenting the student with the next frame, following a response, in an instructional series. The more sophisticated machines present material to many perceptual modes (auditory, visual, tactile) alone or in combination. Frames can also be presented in a booklet in which a student makes a response and discovers the nature of his answer by turning the page or moving a slider.

One advantage claimed for programing is that it is based on empirically established principles. These are: a contingent relationship between answer and content; the ability for the contingency to be met (low error rate); sequencing for materials that build sequentially; a range of examples for full comprehension; and for long programs, a public response.

Condensed with permission from the *American Journal of Orthopsychiatry*, 39(3):418–427, 1969.

The problems in adequately applying learning theory principles to educational technology comprise the major burden of those working in that discipline. At least some have acknowledged their present limitations and future responsibilities. It would seem that an empirically validated product is not yet available for public consumption.

Since so much is expected from programing, it seems reasonable that some criteria be available to allow us to determine whether it can satisfy the tasks being assigned it. There are no means of accomplishing this other than by comparing its effectiveness with other means of reaching the same objective, i.e., by controlled experimental studies.

Another and related means of assessing efficacy is cost analysis. The Congressional Subcommittee on Economic Progress indicated that the amortized costs of computer instructional equipment should not exceed 25 cents per student hour in elementary schools and 50 cents per student hour for special education. Those cost analyses known to the author indicate that computer-assisted instructional programs greatly exceed this suggested figure.

In spite of this bleak picture, standards for program assessment have been offered. One has indicated three phases of program development: development phase, validation testing phase, and field testing phase.

Controlled studies have failed to demonstrate superiority of programing over traditional classroom methods. Most studies attempting to compare programing or automation to traditional classroom methods in teaching reading have found little difference between them.

The factors involved in assessing the dyslexic child's impairments are numerous and involve the participation of many specialists. We might anticipate that the educational psychologist will soon be joining the social worker and physician in remedial efforts.

The use of teaching machines and programed instruction in providing the best educational opportunities possible for these students is potentially too promising to be lost by default. The lack of adequately trained teachers, facilities, and opportunities for rehabilitation is a well-known void which a properly conceptualized and implemented science of educational programing might reasonably be expected to fill. Caution, however, is necessary. An awareness of the inadequacies of traditional methods of education, the vacuous quality of our instructional material, and the limitations placed on students by present educational methods is disquieting. If programs which compete with traditional techniques can do no better, then the situation is serious indeed. Nothing short of a complete renovation of the educational system, with high standards of teaching competence and student performance, will suffice. Considering the priorities of governmental expenditure and the recent meager allotment relative to need for education, this is not likely to occur without massive social pressure and reallocation of priorities and resources.

Planning and Administration of Mental Health Programmes, with Particular Reference to India

BRIJ MOHAN

All communities in the world need mental health planning. Those concerned with mental health activity may put forth their objectives in the following goals of social action: prevention and treatment of mental ills; restoration and promotion of mental health; elevation of the general mental health standard.

Before planning a program the planner has to be clear in regard to the meaning, scope, and implication of each goal. Who are they whose mental health is thwarted? What agencies are there to protect these people? Where and how are those individuals whose mental potentialities are underdeveloped or retarded? What can society do for them? Answers to these questions will serve the preliminary preparation of a program.

Mental hospital—A mental hospital is the largest psychiatric unit that serves the psychiatrically important requirements of a community. There are 36 mental hospitals in India with beds for about 15,000 patients. Most are run by State Governments excepting the two centrally administered ones located at Ranchi and Bangalore and a few private units. Most Indian mental hospitals do not operate in cooperation with community life and are chiefly isolated units.

There are other factors which affect the functioning of mental hospitals on modern lines. They include the outdated 1912 Indian Lunacy Act, lack of adequate financial provisions, and a general indifference on the part of the people and the Government to reconsider mental health needs. Most mental hospitals in India administer somatic treatment and lack modern equipment and techniques of therapy. They have to be reoriented from custodial to therapeutic goals.

Early treatment center and outpatient clinic—The outpatient clinic is a primary unit of service; it also serves as an inpatient early treatment center by providing some beds where the mental hospital is far from the primary clinic. In a general hospital the psychiatric outpatient clinic may be a part of the general outpatient department. In India many advanced general hospitals are equipped with psychiatric wards.

Day hospital—Mental hospitals alone cannot satisfy the mental health needs of the whole community. A day hospital is useful for those whose illness renders them unable to work but who can otherwise remain well under their families' care.

Children's units—Young ones ought to receive top priority in a program dedicated to the attainment of mental well-being. In India there is a dearth of psychiatric units which are especially designed to deal with children.

Geriatric units—In communities where senile patients are found in considerable number provisions ought to be made for their institutionalization. However, not unlike children, elderly patients too can be treated in their homes. In India we do not find special geriatric units for psychiatric patients.

Condensed with permission from the *Journal of Rehabilitation in Asia*, 10(1): 29-34, 1969.

Units for psychopaths—Mental patients having antisocial tendencies should be treated in separate psychiatric units. Psychopaths and patients who have committed some criminal offense as a result of their mental sickness may require hospitalization. Efforts should be made to coordinate the psychiatric viewpoint and legal aspects.

Institutions for alcoholics and drug-addicts—In communities where the prevalence of alcoholism and drug addiction is high, separate units must be established for those "at risk." So far we have no special agencies in India to deal with alcoholics and drug addicts.

Colonies for the mentally defective and epileptics—Constructive and socially useful management of mentally retarded children and epileptics must constitute a plan of the mental health program. The establishment of such colonies at suitable places will meet specific needs of different communities. Proper employment, treatment, aftercare and living facilities should be the characteristics of such a colony. Management of mental retardation varies from one place to another. In almost every country there is a gap between theory and practice in diagnosis, therapy, and education. For our country we will have to examine the suitability of the management and treatment system.

Rehabilitation units — Aftercare homes, sheltered workshops, and working settlements are the main units where patients can be provided re-adaptation to normal life.

The Health Survey and Planning Committee (Ministry of Health, Government of India) has outlined preventive mental health projects of a pilot type which can be undertaken at a small cost. Steps should be taken to materialize such schemes without delay.

In India we find a staggering lack of institutional facilities and trained personnel in the area of psychiatry. The Mudaliar Committee realized that an enormous number of patients require psychiatric help. In India the ratio of mental patients is not less than 2:1000 of population; that is to say, about a million persons require hospitalization. This does not include defectives and epileptics who average about one in two hundred of the population. If it includes the psychoneurotics as well, the requirements will increase up to six to eight million beds.

To quote from the recommendations of the Committee, "we . . . cannot help coming to the conclusion that there is a general sense of complacence in regard to mental disease. This is perhaps born of the general impression that the incidence of mental illness in this country is not high. While no systematic representative surveys have been carried out, the estimates mentioned . . . should be sufficient to remove such an impression. There is, therefore, urgent need for the setting up of preventive mental health services, for the institution of training facilities for meeting these needs and for research and survey programmes."

Recent Cases

Whitree v. State of N.Y.—Court of Claims N.Y., (5/14/68) 290 N.Y.S. 2d 486, 56 Misc. 2d 693

The cause of action here was predicated on the alleged negligence of the State doctors in providing psychiatric and ordinary medical care to the claimant while an inmate at Matteawan State Hospital from May 19, 1947, to September 8, 1961. Following a violation of his probation for an assault charge, claimant was committed to Bellevue Hospital where a psychiatric examination presented a diagnosis of "paranoid condition in a chronic alcoholic." While confined at Matteawan claimant was psychiatrically examined only seven times in six years, of which only three were of any depth and they were all in the first six months of said confinement. The court held this constituted inadequate treatment, and alluded to the woefully inadequate medical records as further proof of this view.

The State cannot be held liable for the initial commitment, where its agents acted on committing papers which were proper on their fact. However, when medically considering the patient the State must be held liable for not investigating facts which might have developed a different diagnosis.

The State was held to be guilty of malpractice, and the damages recoverable are for all personal injuries, including the pain and suffering which flowed from the tortuous act. The injuries from the malpractice were: false imprisonment (12 years, 4 months); moral and mental degradation; pain and suffering from attacks and beatings; physical injuries sustained; and loss of earnings during period of incarceration, resulting in an award of $300,000 in damages.

Massachusetts v. Leis, Massachusetts Supreme Judicial Court, 1/09/69, 37 L.W. 2418

The constitutionality of Massachusetts statutes outlawing possession, use, and sale of marihuana was attacked on the grounds that they are unreasonable because based on insufficient facts, invade the right of privacy, are overly restrictive, and are a deprivation of equal protection of the law because the use of alcohol is not similarly prohibited.

The court rejected the first argument on the grounds that the legislature is not required to investigate thoroughly available scientific and medical evidence when enacting a law. Further, the court noted that there is expert testimony which justifies the conclusion that marihuana is a "mind-altering" drug that may cause a state of euphoria and hallucinations or mental confusion and acute panic. The court also cited in support the considerable evidence that marihuana leads some people to use more dangerous drugs. The court did note that there is no evidence of a direct causal relationship between use of marihuana and other drugs but such evidence, it said, is not necessary.

The court rejected the applicability

of the constitutional doctrine used in *Griswold v. Connecticut* to invalidate the ban on the sale of contraceptives, that marihuana smoking is an activity within a "zone of privacy" formed by "the penumbra" of the First, Third, Fourth, Fifth, and Ninth Amendments.

The argument that the marihuana laws are invalid because they are not the "least restrictive alternative" that would fulfill their purpose of protecting the community welfare is rejected on two grounds: the least restrictive alternative doctrine does not apply to drug regulation and there is ample evidence that total prohibition of marihuana is the least restrictive regulation. According to the court, "the effects of smoking marihuana appear to be unpredictable rendering regulation of its use, as opposed to total prohibition, virtually impossible."

Finally, the court rejected the argument that to prohibit use of marihuana and permit use of alcohol violates equal protection of the law, for the two have widely different properties. First, the court noted, alcohol is susceptible to less restrictive means of control; second, there are accurate means of determining its use and abuse; and third, its effects upon the user are known.

U.S. v. Smith, U.S. Court of Appeals, 6th Circuit, (1968) 37 L.W. 2352

In this case the Sixth Circuit adopted the test of criminal responsibility of the American Law Institute's Model Penal Code. Henceforth, when the defendant offers the defense of insanity, the jury is to consider the following questions:

Was he suffering from a mental illness at the time of the commission of the crime?

Was that illness such as to prevent his knowing the wrongfulness of his act?

Was the mental illness such as to render him substantially incapable of conforming his conduct to the requirements of the law he is charged with violating?

Affirmative findings as to the first question and to either the second or third would require a not guilty verdict.

The court refused, however, to adopt the following stipulation of the Model Penal Code: "The terms 'mental disease or defect' do not include any abnormality manifested only by repeated criminal or otherwise antisocial conduct." This section was based on the rationale that mental health facilities offer little hope for curative treatment of persons who demonstrate mental abnormality by habitual violation of the law and that such facilities are already overburdened by patients with considerably brighter prospects for successful treatment. The court, however, did not find this rationale conclusive, noting great dispute over its psychiatric soundness.

In re Buttonow, New York Court of Appeals, (1968) 37 L.W. 2369

Incompetent mental patient's committee brought an action against the hospital director for a declaration that the patient's consensual change from involuntary to voluntary patient status pursuant to a 1964 statute be declared null and void as a denial of due process and equal protection of the law.

The court would not find the 1964 statute unconstitutional, but it did find that a literal reading of it would leave a patient converted to voluntary status without important legal and administrative protections afforded the involuntary patient, such as periodic court review of his detention, a right to a jury trial on the issue of his sanity, and the services of the Mental Health Information Service which has

the duty of reviewing his admission and retention and providing him and other interested parties with advice and relevant information. A withholding from voluntary patients of these procedural safeguards surrounding their involuntary admission would, according to the court, deny them equal protection of the laws and, perhaps, due process of law as well.

To avoid this result and the consequent invalidation of the 1964 statute the court read into it a requirement "(1) that a mentally ill patient, converted from involuntary status be accorded a right to judicial hearing and review of his change in status as well as of his continued retention in such changed status and (2) that he be afforded the same sort of assistance from the Mental Health Information Service as is now furnished those who are in hospitals on an involuntary basis."

The discussion of the lower appellate court that one adjudicated incompetent does not have the legal capacity to agree to the conversion of his status from involuntary to voluntary was dismissed by the court.

Blake v. United States — C.A. 5th Cir., February 12, 1969 (37 L.W. 2504)

The defendant asked the Appellate Court to remand his case to the trial court because it followed the McNaughten definition of criminal insanity. His appeal questioned the correctness of using this old standard, which he claimed did not take cognizance of contemporary thinking.

The Court reviewed the definition, as well as standards used in other jurisdictions. It noted that "(The) American Law Institute Model Penal Code . . . states that a person is not responsible for his criminal conduct if, at the time he commits the offense, 'he lacks substantial capacity either to appreciate criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of law.' We think that the Model Penal Code standard is in harmony with current knowledge regarding mental illness."

The Court abandoned the old standard and replaced it with the variation on the Model Penal Code definition already followed by the Second and Seventh Circuits: the word "wrongfulness," the Model Penal Code substitute for "criminality," is used. "Wrongfulness" would define as insane a perpetrator who is aware that his conduct is criminal but who, because of delusion, believes that he is morally justified." It remanded the case to the trial court to apply the new standard. The Court further held that its new definition of insanity would apply to all prospective cases, as well as to cases then on appeal in the Circuit.

These summaries are based on material prepared by the Legislative Services Branch, Office of Program Planning and Evaluation, NIMH.

Mental Health News Digests

World Federation for Mental Health

The new headquarters of the World Federation for Mental Health are in Edinburgh, where the Royal Edinburgh Hospital has made available the ground floor and basement of a Victorian house "of the style with which Edinburgh abounds," and has redecorated and furnished them for the Federation.

The WFMH, an international nongovernmental organization, has both institutional and individual membership. Its officers and staff are: Professor G. M. Carstairs (Edinburgh), President; Drs. Baltazar Caravedo (Lima) and Norman L Farberow (Los Angeles), Vice Presidents; Dr. Rowland Burnstan (Princeton), Treasurer; Mr. Russell Cook (Geneva), Deputy-Treasurer; Mrs. S.M.C. Kreitman, Administrative Secretary. The Secretariat is located at Royal Edinburgh Hospital, Morningside Park, Edinburgh 10, U.K.

The new editor of the WFMH *Bulletin*, which is published quarterly in English and French, is Ralph Hetherington. The chief aim of the *Bulletin* is to be a channel of communication between the various national associations of mental health and a forum for exchange of news and views between individual members. It is sent free to all members and associates.

The next annual meeting of the WFMH will be in Washington, D.C., on November 17-21, 1969. The meeting will be held jointly with the U.S. National Association for Mental Health; it is the first time the WFMH has met in the U.S. One topic for the meeting will be "Community Health and the Mental Health Worker," which will be discussed by distinguished workers from Asia, Africa, South America, Europe, and the U.S. A second main topic will be "Social Responsibility of the Mass Media," which will have presentations by representatives of TV, radio, journalism, and the cinema. Information about the meeting may be obtained from the chairman of the Organizing Committee: Dr. Paul Lemkau, The Johns Hopkins University, 615 N. Wolfe St., Baltimore, Md. 21205.

New Chief of WHO Mental Health Section

The new chief of the Mental Health Section of the World Health Organization is Dr. Boris Lebedev. Dr. Lebedev has been a staff member of the Section for four years and formerly was director of the Bechterev Research Institute of Leningrad.

Rural Mental Health Centers

In a recent tabulation of the number of community mental health centers, the National Institute of Mental Health reports that centers are now slated for 23 percent of the country's rural county population.

In 11 States, centers to be created with the aid of Federal construction and staffing grants will cover more than one-third of their rural county populations. Among the States with the highest mental health service coverage for rural county residents, based on grants awarded up to early 1969, are: Kentucky, 88 percent; North Dakota, 63 percent; and Vermont, 44 percent. Colorado, Massachusetts, Montana, and Michigan range from 39 to 42 percent. Pennsylvania, Florida, New Hampshire, and South Carolina range from 33 to 38 percent coverage.

Among the States which, up to early 1969, have no funded centers covering rural counties are: Connect-

icut, Rhode Island, Delaware, New Jersey, Utah, Alaska, California, Nevada, and Oregon. Approximately 2,260,000 citizens reside in the rural counties of these States.

Of the 500 poorest counties in the country, 486 are rural. Funded centers will serve 122, or 25 percent, of these. Of the 3,134 counties in the United States, 2,160 are outside of standard metropolitan statistical areas, and more than 50 percent of their residents live in communities smaller than 2,500. Most of the 134 new rural centers will cover several counties, using mobile treatment teams or satellite clinics.

Since the first Federal grant for community mental health centers was awarded in 1965, more than 350 centers have been funded in 49 States, Puerto Rico, and the District of Columbia, covering areas in which more than 54 million Americans reside. By 1980, some 2000 centers are projected by the national community mental health program. A total of $218,547,589 was expended in Federal aid for centers by the end of fiscal year 1968.

Nursery School for Patients' Children

At the Bronx (N.Y.) State Hospital preschool children of hospitalized mothers will be attending a nursery school on the hospital grounds. The program will be divided into two phases: for the first six months the school will be on the hospital grounds and later the children and staff will move to a community setting.

About 35 preschool children and their mothers will be in the program. The mothers will have daily contact with their children during the three-hour nursery school sessions and will participate in its activities.

During the six months the school is on the hospital grounds, teacher aides will work with the mothers individually on how to help their children develop new learning skills. The mothers will also meet in parent education groups to discuss child rearing and family life. When the school is moved into the community, the mothers will continue to meet weekly with the teacher aides. At the end of the year the children will be referred to schools in their communities. The education and treatment programs will continue for at least six months even though the patient may have been discharged.

Dr. Carolyn Goodman is director of the Hospital's Family Treatment, Education, and Research Center.

American Medical Society on Alcoholism

A new society—the American Medical Society on Alcoholism, Inc.—has been formed to interest physicians in problems of alcoholism and addictive disorders. Membership is limited to physicians.

National officers are Ruth Fox, M.D., President; Marvin A. Block, M.D., Vice-President; Percy E. Ryberg, M.D., Treasurer; and Frank A. Seixas, M.D., Secretary. Applications for membership may be addressed to Dr. Ruth Fox, 150 East 52nd Street., New York, N.Y. 10022, or Dr. Marvin A. Block, 371 Linwood Ave., Buffalo, N.Y. 14209.

Associate Degree Programs for Mental Health Technicians

The Southern Regional Education Board is engaged in a project attempting to establish programs for mental health technicians to be trained at the associate degree level in community colleges. It has completed a series of symposia to aid in defining the kinds of tasks and activities that might be assigned to mental health

technicians. During the course of the project it is expected that guidelines will evolve that may be of help to curriculum planners in community programs, as well as to agencies in preparing job descriptions.

"A Survey of Associate-Degree Programs for Mental Health Technicians" by Drs. Alfred M. Wellner and Ralph Simon appeared in the June 1969 issue of *Hospital & Community Psychiatry*. The article points out that beginning with the first two-year program at Purdue University in 1966, by the fall of 1968 there were 26 training programs in community colleges (also called junior colleges), with another 35–50 in planning stages.

Design for Community Mental Health Centers

Five major community mental health centers were developed in Philadelphia during 1965 and 1966. Each organization followed a model that leaned either toward the conglomerate concept of health services on one end of the axis or the single agency concept on the other.

By the term "conglomerate" is meant a group of organizations bound together and given direction by a central organization. Each subsidiary organization retains independence to an extent that allows it to maintain its own creativity and responsibility for pursuing its goals as it sees fit. This freedom, however, is contingent upon the ability to add specifically to the objective of the central organization. On the other hand, the single agency, or monolithic model, refers to that organization which tends to increase its own size in order to produce a given goal.

The Pennsylvania Hospital Community Mental Health Center reflects an example of a conglomerate which is now in its fourth year of operation and includes six independent agencies and the State hospital system. Early in its development, it took the position that it was impossible to meet the mental health needs of a population of 136,000 people creatively and effectively through the formation of a monolithic organization. As a result, almost one-half of the funding is disbursed to subsidiary agencies for the provision of specific services.

The conglomerate model is not new in the field of finance, but is rare in the field of health and welfare services. Although one must continually evaluate whether such models are transferable and effective, it was felt that there was need to alter the tendency to stick to the monolithic model in order to provide services to a large geographic area. Additionally, and perhaps most important, it was determined at the outset to see the Center as a means of stimulating the growth of additional resources within the community, and not as a means of providing all services centrally.

This subcontract relationship pattern initially brought into the conglomerate an agency specializing in rehabilitative work for the mentally ill and another specializing in the treatment of alcoholics. Additional subcontracts were then entered into with an agency to provide the psychiatric care of children while still another contract was established with an organization which agreed to set up a daycare facility for well children. Finally, a contractual arrangement was entered into with a halfway house for young women.

The Center, in turn, then became a subcontracting agency for the State hospital system and agreed to take responsibility for the operation of a 60-bed unit within that facility. In all these instances, the Center determined

that rather than apply for funds and then attempt to secure staff from these specialized agencies, it would do best to enter into negotiation and contract arrangements that would strengthen those organizations and perhaps alter their focus.

Experience to date has been encouraging. Support of these agencies has given rise to further developments in their concepts of care and stimulated them to expand their organizations in additional ways to find better and new ways of reaching the population to be served. The psychiatric service for children has expanded the concept of its goals and has now incorporated within its own organization a specialized group for the treatment of autistic children. The agency serving alcoholics has moved well beyond its commitment to the Center's catchment area and is endeavoring to set up a regional area of responsibility within the city of Philadelphia so that better care can be given to those alcoholics who are still treated as criminals.

The subcontract itself specifies the staff commitments made on the part of the other agencies to this joint program. The narrative descriptions indicate the nature of services to be provided for the catchment area population including workshops, vocational counseling, and resocialization programs for one of the agencies. Funds from Federal and State sources are passed on to the subcontract agency in bulk and are then used by that agency for the associated costs. Easy access to professional records and the presence of agency representatives in the central organization building reflect some of the means used to maintain continuity of care for the patients.

The conglomerate model of a community mental health center not only provides the means of expanding professional services within a geographic area, but also does this at a reduced overhead cost and with greater professional efficiency at a time when there is a shortage of professional staff throughout the country. It has turned out to be most efficient to add funding and additional services where a core of professional, trained staff exists rather than to "pirate" staff from other agencies with higher salaries. The experience has been so positive that the Center is now attempting to develop retardation services for this catchment area by using the same conglomerate model and adding subcontract relationships with agencies to provide daycare and rehabilitation for this special service group. The effectiveness of any model design will ultimately be judged by its success in helping to reach established goals. Effective and humane treatment of the mentally ill in the community and avoidance of long-term hospitalization are basic objectives of this program. In the few years of the Center's operation, the admission rate to the State hospital system from this urban geographic area has been reduced from 23 per month in early 1965 to a present total of one per month in 1969. This encouraging change is not sufficient, but it does suggest that the conglomerate model for community mental health centers may well be applicable to other catchment areas in the country.

Robert Fishman is Director of Program Development at the Center.

Major Findings and Principles of the Joint Commission on Mental Health of Children

The Joint Commission on Mental Health of Children was established by Congress to study the mental health of children and youth in the U.S. and

to recommend changes of a preventive and remedial nature.

The Commission organized its work around six task forces and four committees. These groups concluded that positive mental health follows a predictable developmental pattern which includes the following abilities: reasonably accurate perception of reality and the capacity to act on that reality; ability to learn and to make use of the acquired knowledge; capacity for developing adequate social and interpersonal relationships satisfying both the individual and others involved; ability to exercise adequate impulse control, especially as related to sex and aggression.

While we do not know all the causes of mental, emotional, and behavioral dysfunction, we know that mental health must be viewed as an interaction between biological, interpersonal, and environmental factors.

The Commission considered almost half the nation's population, i.e., the 100,000,000 individuals under 25. Of this number, 0.6 percent are psychotic and need immediate care and treatment, and 8 to 10 percent need psychiatric services.

Only 10 percent of those in need can be served by present professional mental health services and personnel. Many present care arrangements are little more than custodial institutions which offer little in the way of habilitation or rehabilitation.

Essentially, the Commission proposes a fundamental shift in strategy for the deployment of resources in the service of optimizing human development. It was the consensus of most of the Commission's task forces and committees that highest priority should be given to: comprehensive and systematic services which will insure the initiation and maintenance of physical and mental health of infants, children, and youth; a broad range of currently unavailable remedial mental health services for the seriously disturbed, juvenile delinquents, mentally retarded, and otherwise handicapped children and their families; the development of an advocacy system for children and youth at every level of government to insure the effective implementation of these desired goals.

The proposed services should cover the entire range of child development, from systematic maternal and infant care at one end of the spectrum to the transition of the adolescent and college age youth into effective adulthood at the other.

To implement these recommendations, the Commission proposes the establishment of a network of comprehensive Child Centers that would provide a center for every thousand families.

High School Students and Mental Health Activities

The Maryland Association for Mental Health has announced that the Katherine B. Cullison Award, which was established to encourage interest and activity on the part of high schools in mental health, was made to Severna Park High School in Anne Arundel County and to Boonsboro High School in Washington County. Students compete for the award by sending their plans for a mental health project to the Association, and the winners receive a plaque and funds toward carrying out the project.

The Junior Mental Health Club of Severna Park High School received the Award for its plans to convert a dayroom at Crownsville State Hospital into a coffee house for patients. The Health Careers Club of Boonsboro Senior High School shared the

Award for plans for a mental health week at the school.

Crisis in Psychiatric Hospitalization

In a recent report the Group for the Advancement of Psychiatry takes issue with the premise that "the only good psychiatry is treatment in the community." Entitled *Crisis in Psychiatric Hospitalization,* the study was formulated by the GAP Committee on Therapeutic Care.

The report opens with a review of the changing status of hospital psychiatry with particular reference to its social role and an evaluation of its functions in the admission, treatment, and discharge of patients, followed by a presentation of positive reasons for hospital care as opposed to a "hospitalization-by-default" concept. Five examples show how the psychiatric hospital can be effective in helping troubled persons. In the next section, the reasons for hospital care are stressed and ways for reducing barriers to admission are suggested.

A case history is presented as a model of the contribution of total diagnostic and therapeutic intervention that takes into consideration the relationship of the patient's dynamic interactions with his milieu. The section on discharge describes the changing position of the psychiatric hospital in relation to community resources.

The conclusion stresses concern about the movement away from the psychiatric hospital toward other techniques of patient care and ends with a statement emphasizing the progressive aspects of the extension of mental health services into the community that the authors consider long overdue, but warning that psychiatric hospitalization is not a sign of failure and that psychiatric hospitals provide unique functions in the continuum of care of the mentally ill.

Copies of *Crisis in Psychiatric Hospitalization,* GAP Report No. 72, may be obtained at $1.00 each from the Publications Office, Group for the Advancement of Psychiatry, 419 Park Avenue South, New York, N.Y. 10016.

Psychiatry for Nonpsychiatrist Physicians

A second WICHE progress report —*The Assessment of Short-Term Seminars in Psychiatry for Non-Psychiatrist Physicians*—has been published. Edited by Judson B. Pearson, Ph.D., who is director of the GP-Evaluation Project at WICHE, the monograph presents findings of the last two years of a five-year research to evaluate the effectiveness of the seminars.

WICHE's address is: University East Campus, Boulder, Colorado 80302.

New Gerontology Publication

Occasional Papers in Gerontology is a new monograph series published by the Institute of Gerontology—The University of Michigan-Wayne State University. Some of the recent titles are *Who Are the Aged: A Demographic View*; *Goals of Comprehensive Health Care in Advanced Old Age; Living in the Multigeneration Family; Trends in Early Retirement; The Country of Old Men: Studies in the Psychology of Later Life; A Therapeutic Milieu in a Mental Hospital—A Visual Essay; Preparation for Retirement: An Educational Program.* Additional information may be obtained from the Publications Office, Institute of Gerontology, Room 1510 Rackham Building, The University of Michigan, Ann Arbor, Mich. 48104.

Psychotherapy and Casework

The Group for the Advancement of Psychiatry has released a position statement entitled *On Psychotherapy and Casework*. The 32-page statement was formulated by psychiatrists from various parts of the U.S. who comprise the GAP Committee on Psychiatry and Social Work.

The statement has three purposes: to explore some of the roots of the conflict of ideas in the contemporary approach to emotional disorders; to examine the manifestations of this conflict in social work and psychiatry against the background of their historical development; to present a position that may help clarify the issues involved and provide a basis for the further study of the nature of the training and practice of workers in both disciplines.

Copies of *On Psychotherapy and Casework*, GAP Publication No. 71, may be obtained at $1.00 each from the Publications Office, Group for the Advancement of Psychiatry, 419 Park Avenue South, New York, N.Y. 10016.

* U. S. GOVERNMENT PRINTING OFFICE : 1960 393-634/1

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PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL INSTITUTE OF MENTAL HEALTH
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